Law Reform Commission of Canada
Commission de reforme du droit du Canada

PROTECTION OF LIFE

sterilization

Working Paper 24

Law Reform Commission
of Canada

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STERILIZATION

IMPLICATIONS FOR MENTALLY RETARDED AND MENTALLY ILL PERSONS

1979

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Notice

This Working Paper presents the views of the Commission at this time. The Commission's final views will be presented later in its Report to the Minister of Justice and Parliament, when the Commission has taken into account comments received in the meantime from the public.

The Commission would be grateful, therefore, if all comments could be sent in writing to:

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Foreword

This Working Paper on sterilization of the mentally handicapped persons is part of the Protection of Life series. It follows the Working Paper on *Criteria for the Determination of Death*, which the Commission published in March, 1979.

The moral, juridical and social problems posed by sterilization of mentally handicapped persons are real indeed. Work on these problems is under way at this time in several provinces of Canada.

The sterilization of persons living with mental handicaps is of concern not only in terms of criminal law, but also in terms of civil law. The Commission is quite aware that in this subject provincial law plays a very important part, notably in the formulation of legal procedures for the effective protection of those of our fellow citizens who happen to be mentally handicapped. The Commission's final recommendations, to be based on public response to this Working Paper, will ultimately have to address the kind of protection which can be accorded most aptly by Parliament through the criminal law. However, it would be a vain and hardly scientific exercise to avoid systematically all reference to provincial jurisdiction in this subject, since it demands consideration which is at once comprehensive and practical.

The Commission expresses its gratitude to those people from several provinces who aided us with their knowledge of this subject prior to the publication of this Working Paper. Their comments were most helpful.

Now the Commission hopes to engage the interest of the public in an expression of thoughtful opinion about this important subject. The Commission earnestly seeks comments, therefore, about the general direction of the policies proposed in this Working Paper as well as about the tentative recommendations specifically advanced.

Introduction

> Eugenic sterilization is a biomedical intervention that has given us eighty years of experience with the legal, moral, and philosophical problems that arise when society decides to use medical means to impinge on the rights of some people in order for others to benefit.[1]

The practice of sterilization[2] has a history of religious, medical, and social controversy. At one time or another, people have called for its complete prohibition[3] while at other times others have argued that it be involuntarily imposed.[4] Sterilization as a medical procedure is distinct,[5] because except in rare cases, if the operation is not performed, the *physical* health of the person involved is not in danger, necessity or emergency not normally being factors in the decision to undertake the procedure. In addition to its being elective it is for all intents and purposes irreversible.[6]

The importance of law to sterilization is related to the consensual nature of the procedure. The presence of consent, actual or implied, may remove the legal liability of the physician who undertakes to perform the operation. Although there have been no cases of doctors in Canada being sued for medical malpractice or charged with assault solely for performing the operation, some legal opinion suggests that this is technically possible.[7] It is therefore an area in which medical practitioners could clearly benefit by knowing their legal liabilities.

An informed consent by the subject of a medical procedure, provided other conditions are fulfilled, usually (and rightly) relieves the physician of any such liability as long as the procedure is not performed negligently. Sterilization has not, however, been restricted to persons who have given their informed consent. It has been performed without consent or with third party consent for many years. It is mainly with the latter cases that we will be concerned in this paper.

Within the parameters of the Law Reform Commission's study of criminal law relating to medical procedures, a number of particular areas of medical or surgical intervention have shown to be enigmas of the general rules that have or will be addressed in grappling with the problems of meshing modern medical practice and the law. Sterilization falls into this category of enigmas that the Commission felt needed to be addressed in a particular rather than a general way. The usual meaning of *benefit to the individual* did not appear to apply to sterilizations which are performed for reasons other than the treatment of illness or disease. As well, there is a legislative and practical history of sterilization that has led to an increasing controversy about social and ethical reasoning surrounding the practice and subsequently a need to develop public policy seemed evident. Finally the Commission was well aware that if any abuses or dilemmas were to be raised with respect to sterilization, they would most likely arise with persons who are mentally handicapped. For these reasons, the Commission decided to confront this issue in a separate study. In so doing, the Commission has taken into account the deep-seated misunderstandings about mentally handicapped persons including their abilities and potential, and their place as full citizens in our society. The Commission is not unaware that jurisdictional questions may well be raised with respect to the content of this paper. However, the very real problems raised and the need to make the most informed choices with respect to sterilization could only be made by undertaking an analysis of the wide spectrum of the question. The Commission is also of the opinion that there are convincing arguments for uniformity for consent requirements and tests of capacity in the case of mentally handicapped persons.

Specifically, we will deal with the sterilization of persons with *mental handicaps*. This term is used in this paper to refer to two groups of persons — those who are mentally ill and those who are mentally retarded.[8] These two categories of persons have been chosen as the focus of this paper for a number of reasons. First, because of a legislative history[9] which particularly selected out these groups as being exempt from otherwise mandatory consent requirements. Secondly, because of a general attitude towards such persons as being

excluded in one way or another from the rights and responsibilities of other members of our society. And thirdly, because of increased public concern about lack of control of the reproduction of mentally handicapped persons consequent upon the adoption of policies of deinstitutionalization.

The first section of the paper examines the medical, social, and legal definitions of mental illness and mental retardation. In the second section the positions that have been taken concerning the sterilization of these groups are presented along with a detailed examination of the social, bio-medical, and moral arguments that have been advanced. The issues that are raised by non-consensual sterilization are outlined in the third section, followed by a discussion of whether there are conditions under which non-consensual sterilization can be justified from the point of view of the criminal law. In the final section of the paper legislative alternatives are analyzed and guidelines are proposed.

I

The Population

Any discussion of an issue which involves the mentally retarded or mentally ill is immediately problematic because few definitive statements can be made that would apply to all or even a large proportion of persons so categorized.

Determining a suitable legal framework for ensuring appropriate practices is also made more difficult because of this lack of precision. As one expert has put it:

> In any discussion concerning legislative provisions and their interpretation and implementation, we need to keep in mind that the terms mental retardation or mentally retarded persons, lack exactitude and in most instances therefore cannot be related to specific legislative provisions without further qualification.[10]

It is obvious that there are limits to what can be said without, at a minimum, some understanding of who we are talking about. The rationale for policy development respecting persons classified as mentally handicapped cannot be divorced from the conceptualization of the handicap. Because of this, a variety of definitions — bio-medical, psychological and sociological — that have been used for mental illness and mental retardation will be discussed.

1. Mental Retardation

A. Definitions

Defining mental retardation presents two immediate problems. First is selecting the general perspective from which one begins; that is, does one adopt a bio-medical, a psychological, or a sociological definition? Secondly, which of the differing approaches within a given perspective should be adopted?

In a comparison of different systems of classification of mental retardation according to degree and function, Marvin Gelof[11] compiled a table providing direct comparison of twenty-three such systems by organizations and authorities in the United States, the World Health Organization and Great Britain. Classification systems are shown to be based on cause, condition, functioning, prognosis or some combination of these factors.[12]

Gelof made it clear that as knowledge and concepts have changed, different outlooks and attempts at assimilations of concepts in terminology have resulted in diverse classifications. Thus some terms have acquired different meanings and some meanings have acquired different terms. According to Gelof:

> . . . Classifications differ in kinds of behaviour or functioning emphasized as criteria. Past, present and future functioning, psychological, intellectual, and social adequacies and their inter-relationships are differently stressed. The amount of reliance placed on I.Q. as a measure of intellectual function or capacity differs. The levels of subclasses according to degree are not consistent.[13]

The definition of mental retardation in most common usage is the one developed by Rick Heber[14] and adopted in its present form by the American Association of Mental Deficiency in 1978:

> Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period.

This definition, an operational one, is characterized by a combination of two aspects of mental retardation — a general deficit in intellectual performance (I.Q. approximately 70 and below) and an impairment of social adaptation. Both of these aspects will be treated below as will the perspective of mental retardation as deviant behaviour.

(i) *Subnormal intelligence*

For over a century subnormal intelligence has dominated scientific conceptions of mental retardation.[15] In 1846, S. G. Howe defined " 'feeble-minded persons' [as those] who ranged in level of incapacity from those with reason enough for simple individual guidance plus normal powers of locomotion and animal action to 'mere organisms' ".[16] In 1914, Henry Goddard expanded the definition of degrees of incapacity by adding the category of *morons* to those of *imbeciles* and *idiots* which were already in use to classify persons who were feeble-minded. In 1941, Edgar Dole defined *mental deficiency* as "(1) social incompetence, (2) due to mental subnormality, (3) which has been developmentally arrested, (4) which obtains at maturity, (5) is of constitutional origin, and (6) is essentially incurable".

Generally it is known that individuals vary along continua according to verbal, numerical, and other aptitudes. With this knowledge, psychologists have developed a number of instruments for measuring intelligence. It has become standard practice to use such tests in classifying people as mentally retarded and in ascertaining their degree of retardation.

The limitations of such tests however, have been seriously questioned. First, they tend only to measure a few abilities and do not reflect other important qualities such as creativity and perseverance. Second, the results of the tests are regarded by many as unreliable, varying from one testing to another depending on such factors as the emotional and physical state of the person being tested at the time of testing. Under these circumstances the tests can only give an approximate measure of an individual's ability. When handicaps such as deafness, cerebral palsy or dyslexia exist, the tests are even

less sensitive. Moreover, performance in intelligence testing often improves with coaching and practice. It has been reported that simply by taking one previous test an average score can be raised five points[17] and with coaching can improve 25 to 30 points. The implications are obvious. If practice can improve one's I.Q. test score, then it is likely that certain social settings will be conducive to higher scores.

Finally, such tests can be shown to be culturally biased. If an individual does not share the cultural experiences and the verbal skills and practices of the groups in which I.Q. tests were standardized, that individual will not score as highly on such tests.[18] Comparing differing ethnic and racial groups and social classes is therefore problematic. Intelligence is a social product as well as an individual quality. Ability to perform well on an I.Q. test may well be as dependent on one's environment and the resources available to an individual as on an individual's innate characteristics. Verbal and social skills have been shown to be better developed in non-institutional settings than in institutional settings. Thus, institutionalized persons are more likely to be classified as subnormal intellectually not necessarily because of their intellectual capacity but because the skills used as measures of intelligence are generally less developed in institutional settings. The use of I.Q. tests, which may be neither valid nor reliable, to classify persons as mentally retarded is therefore questionable.

(ii) *Behavioural adaptability*

As seen from the American Association of Mental Deficiency definition, level of intelligence is only one element used in the delineation of mental retardation. The second is the behavioural and emotional adaptability of the individual. The assumption is that there is a continuum of capacity to manage one's personal affairs and to be able to cope with one's physical and social environment. At some point on the capacity continuum, persons are said to be unable to adequately function and are classified as mentally retarded. The problem is the difficulty in determining at which point this label should be applied. The real extent of personal incapacity in a population

is determined to some extent by the societal demands placed upon individuals as well as the number and type of services that are available to assist the individual in meeting those demands. Therefore, the level of incapacity accepted for special attention and care depends on the perceptions and tolerance of families, peer groups, the community and the bureaucratic institutions. Also it will likely change over time depending upon the situation in which a person is placed and the demands made upon that person.

The problems of determining an individual's personal capacity is complicated when the issue involves sexuality. Since both physical and emotional development and understanding are involved, determination of sexual maturity is difficult generally and further complicated in the case of persons who are mentally retarded. There are at least four recognizable phases in the process of competency and understanding of sterilization. First, there is an age when procreation is possible. Second, there is an age when the implications of procreation can be understood and responsible decisions can be made respecting birth control and procreation. Third, there is an age when an individual can understand the implications of sterilization sufficiently to determine whether to accept or reject such an operation. Finally there is the legal age — an age when an individual is considered by law to be capable of making such decisions.

(iii) *Deviance*

The third way of understanding mental handicap is from the sociological perspective of deviance. Some persons are classified as mentally retarded not so much because of their subnormal intelligence or their inability to adapt behaviourally but because they are perceived as deviant. Jane Mercer[19] characterized mental retardation as an ". . . achieved status in a social system and the role played by persons holding that status". Although this will be dealt with in the following section on models of mental illness, it is also applicable to the mentally retarded.

B. Causes of Retardation

Because the causes of mental retardation have been a basis for both the classification of persons and their subsequent treatment, they will be dealt with here. The use of the term treatment, in this sense, is not confined to the narrow sense of medical treatment but includes the broad range of bureaucratic, legal, educational, and social services available to the mentally retarded.

The causes[20] fall into two general categories:[21]

- bio-medical factors including causes due to inherited disorders (genetic), and causes related to pregnancy, birth and the first days of life; and,

- socio-environmental factors including such considerations as nurturing and deprivation and causes due to infections, accidents and poor nutrition in childhood.

These two general categories are not mutually exclusive. Mental development is now usually considered to be a result of interaction between inherited and environmental factors. If we assume the current clinical definitions of mental retardation, a definitive cause or distinct syndrome can be recognized in only about forty percent of the cases.[22]

(i) *Bio-medical disorders*

A number of genetic defects have been positively linked with certain types of mental retardation. In some cases inherited disorders can be traced back to parents, one or both of whom may be carriers of a defective gene or chromosome which may be either recessive or dominant. In others, the genetic defects may occur spontaneously or as a result of drugs or radiation.[23]

There are a variety of other bio-medical disorders which are potential causes of mental retardation but which are not inherited disorders. These include *pre-term* low birth weight[24]

(and thus susceptibility to respiratory problems, infections, and chemical abnormalities, all of which increase the chances of neurological damage); and complications due to congenital abnormalities, blood incompatabilities, side effects of maternal diseases, respiratory problems and injury occurring during the birth process (*e.g.* hemorrhage in the brain, or anoxia or some combination of these conditions can cause degrees of mental handicaps ranging from minor learning disabilities to severe retardation).

There are also conditions which, because they affect the health of the mother and consequently the health of the fetus, can contribute to retardation. Such conditions may involve a specific health condition of the mother (for example, heart disease) or conditions which relate to the pregnancy itself. Included among these are lack of essential nutrients or oxygen in the mother's blood, RH antibody factors, viruses, bacteria, parasitic organisms, radiation, drugs and physical trauma.

(ii) *Socio-environmental factors*

Socio-environmental factors include two major categories — a child's emotional, social, and learning environment; and, infections, accidents, and poor nutrition.

An environment that fails to meet the emotional and sensory needs of an infant can have an effect on brain development. The results may range from simple learning disabilities to severe mental retardation and may or may not be reversible depending on the timing and type of deprivation.

Infections, accidents and poor nutrition in childhood which result in mental retardation are equally varied. The most common causes of mental retardation in infants are infectious diseases,[25] (some, such as rubella, which are preventable), poisoning, and head injuries; these may be purely accidental or may have precipitating causes arising from poor home care, inadequate nutrition, emotional disturbances and neglect. Child abuse may result in neurological damage from injuries to the head.

C. Prevalence of Mental Retardation

The overall prevalence of identified mental retardation is generally estimated at about two to three percent of the population.[26] Stevens[27] concludes that mental subnormality ". . . is a constellation of syndromes. It is not a disease, although it may be a result of a disease. It is more accurate to describe it as a condition that affects from two to three percent of the total population".

Generally, levels of intellectual deficit have been broken down in a number of categories — ranging from mild to profound. Intelligence quotient has traditionally been the predictor of adaptability. Heber[28] estimated that the percentage of educable mentally retarded persons (generally those with I.Q. above 50) was 70 to 80 percent of the total mentally retarded population. In a comparative study of rates of retardation by severity, Conley[29] found there were fluctuations in rates, although in all cases the majority of persons were mildly mentally handicapped. Clarke and Clarke[30] estimate that about three-quarters of those classified as mentally retarded persons being assessed with I.Q.'s between 50 and 70 with the vast majority of these functioning more or less adequately in the community and causing no special concern to the authorities. Lewis[31] and O'Connor and Tizard[32] found[33] that the ratios of estimated prevalence of severe to moderate to mild subnormality were 1 to 4 to 15, that is 5 percent, 20 percent and 75 percent respectively. Using I.Q. scores, their estimates are therefore that 25 percent of mentally retarded persons have I.Q.'s below 50, and 75 percent have I.Q.'s assessed at between 50 and 75. Others have estimated that of the 250,000 mentally retarded people in Canada, only 5 percent are severely mentally retarded while 80 percent are only mildly affected.[34]

The problems with such numbers are evident, however, since the number is directly related to the definition and the testing instrument used.[35] Thus, the manual written by the technical-professional arm of the Canadian Association for Mental Retardation as an orientation guide for persons in the

field of mental retardation[36] cautions about attempts to determine prevalence of mental retardation. They point out that the definition of mental retardation has a significant effect on the determined prevalence figures.

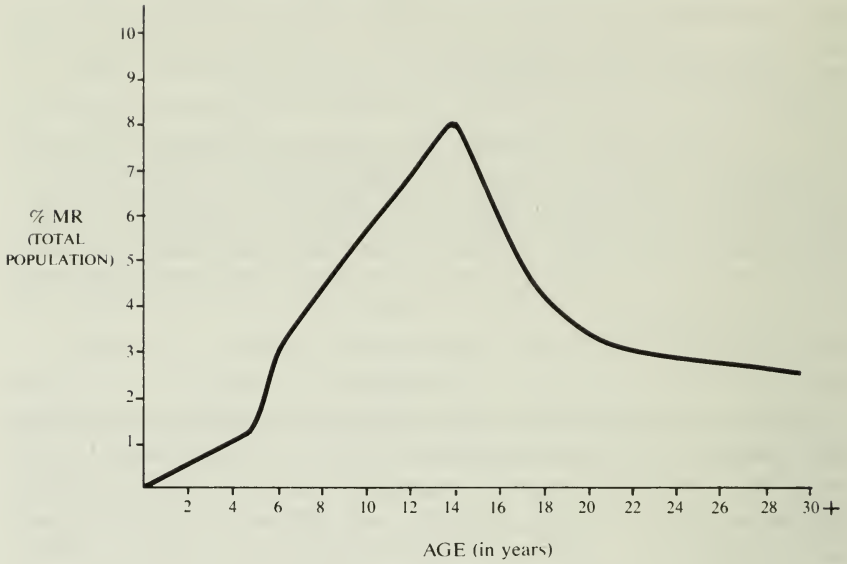
> The much disputed 3 percent figure for prevalence often quoted in North American literature is much inflated. It holds in theory when the two main criteria for defining mental retardation are intellectual functioning (as determined through tests), and social adaptability. But because the mildly retarded group is numerically the largest, raising or lowering the cutoff point by only a few points for deciding who is and is not considered retarded can dramatically affect the prevalence of mental retardation.

In examining the degrees of mental retardation as well as the cut-off point between *dull-normal* and *mildly retarded*, it must be continually kept in mind that we are dealing with a continuum and not with specific and different groups of persons. Thus, ". . . when the test of social competency is taken into account, who is retarded, and who is not, becomes a matter of relativity".[37] Account must also be taken for those who are mentally retarded and those who have other disabilities in addition to their mental retardation.

Both intelligence quotient and adaptive behaviour can be modified. I.Q. can be altered both up and down dependent on a child's life experiences and is subject to development through interaction between the person and his or her social environment. An individual's capacity to adapt to his environment is determined to a greater or lesser extent by socially defined age-specific norms.[38] Emotional capacity and development must also be taken into account as part of the assessment of adaptive ability.

The overall prevalence of mental retardation will therefore vary with the age and situation of the group considered.[39] Cross-cultural analyses have shown that the reported prevalence of mental retardation rises dramatically at about the age of school entrance and increases steadily until the middle teens (legal age of school termination) after which it begins to decline. The following pattern emerges:

THE PREVALENCE OF MENTAL RETARDATION BY AGE



N.I.M.R. Orientation Manual, 1977, p. 83

Such a finding more accurately reflects the systematic demands for intellectual functioning and adaptive behaviour that exist in the school system than the actual incidence of subnormal intellectual ability. "Educational failure itself is so important a factor in bringing mental subnormality to notice that, only half in jest, one public health authority has called universal free compulsory education the single largest 'cause' of mental subnormality."[40] It is a fact that social competence is susceptible to growth, and is always relative to the demands of the particular environment in which the individual functions.[41]

According to Begab, it is this dynamic nature of mental retardation that denies ". . . the long cherished bromide of 'once retarded, always retarded'. Failure to induce change early in life and thus prevent retardation in its primary sense need not doom an individual to a lifetime of maladaptation . . . 'cure' through behaviour change is possible".[42]

In summary, then, the definition of mental retardation and the determination of its prevalence are problematic for a number of reasons. First it is based on a combination of factors including a deficit in intellectual development and an impairment in social functioning ability and has a variety of causes. It does not fit therefore a strictly medical model or definition but rather is a social-administrative category. Secondly, the level of the functioning disability varies significantly (from mild to profound). "The gap in intelligence and functioning between the more profoundly mentally retarded and the mildly mentally retarded is greater than the gap between mildly mentally retarded and 'normal' persons."[43] Thirdly, mental retardation is not a static condition, but is subject to change. That one of the elements of mental retardation is a *deficit in adaptive behaviour* means that it is a product of the interaction between individual capacities and social demands. Changes in functioning ability or in the social demands made upon a person may result in a person no longer being classifiable as mentally retarded. The degree and nature of stimulation and education involved in the early nurturing process will have a direct correlation with the development of an individual. Therefore reliable assumptions made about individual potential cannot be made. Fourthly, it is a label or classification which is applied to a very diverse group of people.

> It is clear, therefore, that mental subnormality is not in itself a scientific category, but rather a social-administrative concept. Whether defined in terms of I.Q., social incompetence, or educational failure, any borderline will tend to be arbitrary, and especially around the particular score or grading chosen will, by itself, lead to a degree of misclassification.[44]

2. Mental Illness

The problems involved in defining the concept of mental illness are even greater than those encountered in the area of mental retardation. Shah states it this way:

> . . . the labels reflect specific ways of conceptualizing the problems, the conceptualization used relates to specific treatment models, and the labels applied tend to determine the ways in which the deviant will be handled and the particular agencies to be involved in his case.[45]

There are three schools of thought about the meaning of the concept of mental illness, and even within these there are different opinions. One explanation of this concept is based on the *medical* model,[46] another on the *socio-developmental* model, and the third on the *deviance* model. These are not necessarily mutually exclusive approaches. They will be dealt with here in only the most cursory manner.

A. Medical Model

The medical conceptualization holds that "mental illness is an illness like any other". In medicine, the term *illness* is used to denote an ". . . undesirable alteration or change away from optimum levels of organic bodily functioning".[47] On this basis the difference between mental and bodily disease is that the former, affecting the brain, manifests itself in mental symptoms, while the latter, affecting other organ systems, manifests itself in those parts of the body.

The medical model suggests that mental illness embraces a number of distinct medical conditions each with a separate cause, prognosis, and potential treatment. The treatment of these conditions should be handled similarly to the treatment of physical illnesses and is properly the function of a physician specially trained in their diagnosis and in known methods of treatment. The primary focus of this model is on the sick individual and his or her particular psychological problems.[48] It requires that the person be treated for the disease and *cured*. The assumption is that there are underlying organic defects, in most cases still undiscovered, that produce the disturbed behaviour.

Martin[49] divides the "complex of brain disorders" into three categories: conditions partly or fully caused by physiological disorders; conditions attributable to psychological or unknown causes; conditions caused by a combination of psychological and physiological factors. On this basis, one can talk about *organic* mental illnesses — those resulting from acquired injuries or diseases that have damaged the brain and

from congenital defects or inborn damages that affect the brain; or *functional* mental illnesses — those resulting from one or many causes but which always involve psychological factors (such as psychoses [schizophrenia, depression] neuroses, personality disorders, psychosomatic diseases).

B. Socio-developmental Model

The second category, *functional* mental illness, is what is here referred to as the socio-developmental model.

The proponents of this school diagnose mental illness on the basis of maladaptive and nonconforming behaviour as well as manifest disturbances of psychological functioning. The implication, as with the medical model, is that the condition is within the individual. Thus, there are objective symptoms and signs that may be observed in a person independent of his social situation or environment. Because the condition is not in the control of the individual or others, these symptoms and signs indicate a diagnosis that in turn indicates prognosis and treatment. One of the inferences of this approach is that the source of the difficulty is within the person him/herself and in his or her personality development and that the problem can be alleviated or rendered by changing some aspect of the individual's personality.[50] There are a variety of theories about how this can be accomplished. These include psycho-analytic theory, behaviourism, cognitive theory, humanistic theory and existential theory.[51]

C. Deviance Model

The third[52] way of understanding mental illness (and mental retardation) is from a societal perspective. The proponents of this model argue that because the symptoms of mental illness are vaguely defined and widely distributed and because the definition of the behaviour symptomatic of mental illness is usually dependent on social rather than medical contingen-

cies, mental illness may be more usefully considered as a social classification than as a disease.

Szasz[53] conceptualized the inappropriateness of the medical model in the following way. The concept of illness, whether physical or mental, implies deviation from some clearly defined norm. The norm is the structural and functional integrity of the body in the case of physical illness and can be stated in anatomical and physiological terms. If it is a physical disease or defect of the brain, it is a neurological defect, and can be classified as a bodily illness, not as a mental illness. In the case of mental illness, the norm from which deviation is measured is a psychosocial, ethical or legal norm.

People are classified as mentally ill, then, when their personal conduct violates certain ethical, political, and social norms. The problems being dealt with have external rather than internal causes.

Proponents of this view maintain therefore that mental illness is simply an inability or refusal to cope with or adapt to the environmental factors operating on an individual.

From this perspective it has been argued that some persons are classified as mentally retarded or mentally ill not necessarily because they are of subnormal intelligence or are mentally incapacitated but because they are perceived as deviant.[54] On this basis a person will be viewed as a deviant:

> . . . if he is perceived as being significantly different from others in some respect that is considered of relative importance and if this difference is negatively valued.[55]

In other words, it is presumed that if a person's behaviour does not conform with the social norms, then he or she will be classified as deviant. Further, because behaviour tends to fall along a continuum, rather than being a distinct, isolated phenomenon, deviance is viewed as a consequence of the responses of others to a person's action and is both situationally and temporally specific. What is considered deviant behaviour on the part of one person may not be considered

deviant for another and what is deviant at one time may not be treated as deviant at another. It will vary from place to place, from class to class or from society to society. Such an argument maintains that the classification of deviant behaviour as mental retardation or mental illness is then dependent upon who reacts to the behaviour. An inferior status attaches to such a classification and may be sanctioned by both formal and informal response mechanisms. Such sanctions could range from social isolation through to legal declarations of incompetency.

The advocates of this model go on to state that being labelled deviant can change one's self perception and can change one's behaviour patterns. It can lead to seeing oneself as deviant and progressively to acting out that role. Future behaviour would then be predicated upon past reactions of others to one's behaviour. This could then be of particular importance for persons viewed as mentally handicapped. They may readily accept decisions of others who are not *deviant* and agree to actions because they believe they are incapable of undertaking responsibilities which others define them as being incapable of undertaking. The deviant individual or group, it is argued, may then agree to give up certain rights to which the rest of society has access, and to act in a manner appropriate to persons who do not have those common rights.

Some proponents of the deviancy model maintain that psychiatric diagnosis is simply a way of dealing with social problems through the use of *false scientism of medical man*.[56] Such diagnosis is seen as a mechanism of social control with those defined as *experts* (psychiatrists, doctors) being granted the power to label certain behaviour as *mental illness* and aiding the courts in committing those exhibiting such behaviour. From this perspective, psychiatry is interpreted as political action, with scientific legitimacy.

According to the latter two perspectives — socio-developmental and deviance models — seeking the cure for mental illness in traditional medical measures is simply inappropriate.

Those who disagree with these models of deviancy argue that the practice of psychiatry is moving much more toward a scientific[57] base than it has in the past and that fairly objective criteria are being established for many psychiatric illnesses whereby large numbers of psychiatrists having been trained in entirely different settings will still arrive at the same diagnosis. Nevertheless it would appear that the deviance model raises some legitimate concerns about the definition of mental illness which must indicate caution in any approach to these problems.

In summary, then, the definitions of mental illness may often be vague and contradictory. The criteria and norms used in defining *mental* disease can lack the fairly specific, objective, and precise criteria for determining *physical* disease. *Mental disease* may then be used to describe a variety of psychosocial problems.[58] The labelling of a condition as mental illness can lead to the attribution of an inferior status to the individual. The social and ethical consequences of such diagnosis may be significant.

Throughout this paper the terms mental retardation and mental illness have been subsumed under the single term, "mental handicap". This is in no way meant to suggest that this term applies to the same groupings of persons, although in some cases persons may suffer from both mental illness and mental retardation simultaneously. As we have indicated, the definitions, causes, and prognoses of each of these two handicaps are quite distinct. But in dealing with the issue of sterilization, law has generally considered these two groups together. Persons in both groups have been similarly assumed and subsequently found to lack the capacity to manage their own affairs and have been denied civil liberties under the law. Therefore, in deference to convention and for the sake of simplicity, and only for the relatively narrow legal focus of this paper, the Commission has opted to use the single term — mental handicap — for both groupings.

II

Approaches to Sterilization

Despite all these conceptual difficulties, there are groups of people who, one way or another, are labelled as mentally retarded or mentally ill. And it is with respect to persons so classified that the policy of sterilization is to be examined. It will become evident, however, that the conceptualization of the handicap plays a major role in the approaches that have been taken in policy development in this area.

There are a variety of arguments used to support a policy of non-consensual[59] sterilization. There are as well arguments which oppose such a practice. Each of these positions will be discussed in detail. Whether the practice of non-consensual sterilization can be justified poses a number of questions about the treatment of the mentally handicapped generally and the relationship of the individual to the state. Finally, the discussion of non-consensual sterilization raises some issues relating to voluntary sterilization of mentally handicapped persons.

1. Arguments in Favour of Non-consensual Sterilization

The justifications put forth for non-consensual sterilization of the mentally handicapped fall into three general categories: benefits to society and the state; benefits to the handicapped themselves; and benefits to the potential future children.

A. Benefits to Society and State

(i) *Sterilization for eugenic purposes*[60]

The argument that the state benefits from eugenic sterilization is based on the assumption that certain types of individuals are socially more desirable than others, as well as on scientific claims about the inheritability of certain traits. It is argued therefore that attempts should be made to eliminate undesirable traits and encourage desirable ones. The improvement of future generations is said to be accomplished in two ways: (1) by increasing the proportion of desirable individuals by decreasing the rate of propagation of the inferior individuals and thereby eliminating the undesirable traits from the gene pool (negative eugenics); or (2) by encouraging the propagation of desirable individuals by improving or encouraging the desirable characteristics in the gene pool (positive eugenics). The first objective (negative eugenics) is pursued usually primarily by limiting procreation of carriers of undesirable traits through non-consensual sterilization, marriage restriction, sexual segregation, permanent institutionalization and response to genetic counselling. The second is considered attainable by encouraging procreation by those individuals who carry the greatest proportion of *desirable* genes, using such legitimate medical technology as genetic screening and artificial insemination. The primary emphasis of the Eugenics Movement was on negative eugenics and it was from this that much of the legal history of sterilization emanated. The importance of this approach on subsequent legal and social thinking in this area necessitates a brief overview of the development of the movement.

Three events at the end of the nineteenth century appear to have played an important part in the incorporation of eugenics into law in the United States and Canada (British Columbia and Alberta). These were the launching of the eugenics movement by Sir Francis Galton, the *re-discovery* of Mendel's laws of heredity, and the development of simple, safe surgical techniques for the prevention of procreation.[61]

The word *eugenics* is derived from a Greek word meaning *well-born*. In 1883, Sir Francis Galton coined the term and defined it as:

> The study of agencies under social control which may improve or impair the racial qualities of future generations either physically or mentally.

In 1904, Galton officially launched the Eugenics Movement which involved both positive and negative eugenic aims. At the same time the laws of heredity, formulated by Gregory Mendel were rediscovered. Although Mendel's work had been confined to the transmission of simple traits in plants, the eugenists assumed that the principles were applicable in the same way to complex traits in human beings. The proponents of this view argued that mental illness, mental retardation, epilepsy, criminality, pauperism and various social defects were almost exclusively hereditary. Thus social eugenics was launched. Herbert Spencer coined the phrase "survival of the fittest" and he emphasized intelligence and technological innovativeness, which became the criteria for determining whether or not people were qualified for survival. Spencer also advanced the idea that the *fit* were facing depopulization because the *unfit* had a higher reproductive rate. This classification of *unfit* included mentally retarded persons, alcoholics, epileptics, schizophrenics, criminals, prostitutes and others whose physical or behavioural characterizations were considered to be genetically determined and inherited.

In May 1911, the Research Committee of the Eugenics Section of the American Breeders Association, suggested ten remedies as being possibly efficacious "for purging from the blood of the [human] race the innately defective strains". These ten remedies, were: (1) life segregation; (2) sterilization; (3) restrictive marriage laws and customs; (4) eugenic education of the public and prospective marriage mates; (5) systems of matings purporting to remove defective traits; (6) general environmental betterment; (7) polygamy; (8) euthanasia; (9) Neo-Malthusianism; (10) laissez-faire. The committee decided that of these, the first two — life segregation and sterilization — held the greatest potential for effective results.[62]

The legislative history of eugenic sterilization in North America began in 1897 when a Bill authorizing such operations was introduced in the Michigan legislature. It was defeated, however, and the first eugenic sterilization law was enacted in Indiana in 1907. By 1917, fifteen states had adopted such laws and by 1937, a total of thirty-one states, and in Canada, Alberta (1928) and British Columbia (1933) had enacted such legislation.

In 1925, the United States Supreme Court ruled in favour of the constitutional validity of sterilization laws in Virginia, holding that they were a reasonable regulation under the police power and did not violate the due process clause of the fourteenth amendment. In the particular case, the plaintiff was an eighteen-year-old woman, committed to an institution, who was the daughter of a mentally retarded mother and the mother of an illegitimate mentally retarded child. Mr. Justice Holmes, speaking for the court, extrapolated from the particular circumstances of the case, however, and generalized to all cases in his statement:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent one being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes . . . Three generations of imbeciles are enough.[63]

The foundation of the eugenists' argument — the belief that mental illness, mental retardation and criminality are inherited — was thus the basis of the United States Supreme Court decision on the constitutionality of the law.

Studying the eugenic arguments for sterilization, the American Neurological Association's Committee[64] for the Investigation of Eugenical Sterilization (1936) summarized the key points of the argument:

- Mental illness, mental deficiency, epilepsy, pauperism and certain forms of criminality are steadily increasing

- Persons with these diseases propagate at a greater rate than the normal population

- These conditions are hereditary

- Environment is of less importance than germ plasm in the creation of these conditions. Implicit and sometimes explicit in this point of view is that euthenics is against natural selection because it keeps alive the unfit and therefore, is against the racial welfare.

(ii) *The Canadian experience: eugenic sterilization laws in Alberta and British Columbia*

The *Alberta Sterilization Act* (Respecting Sexual Sterilization, Chapter 311 of Alberta Statutes) was drafted in 1928. It was repealed in 1971. During the time it was in effect, 4,725 cases were proposed for sterilization and 2,822 approved.[65] In the final year (1971) 78 cases were proposed, 77 approved and 55 sterilized. The persons who could be referred to the Board[66] for possible sterilization fell into five categories:[67]

(1) psychotic patients;

(2) mental defectives who suffered from arrested or incomplete development of mind which existed before they were eighteen years of age whether arising from inherent causes or induced by disease or injury;

(3) individuals suffering from neurosyphilis with deterioration not amounting to psychosis but not responsive to treatment;

(4) individuals suffering from epilepsy with psychosis or mental deterioration;

(5) individuals suffering from Huntington's Chorea.

There were two reasons for sterilization: there was a danger of the transmission of any mental disability or deficiency to offspring, or a risk of mental injury either to such persons or to the progeny if sterilization were not carried out. Finally, there was a provision included in the Act that no

person associated with the decision or its execution could be liable in a civil action. There was no appeal from decisions made by the Board. Psychotics whom the Board considered capable of giving a valid consent had to give that consent if the operation was to be done. For those considered incapable of consenting, a husband, wife, parent, guardian or the Minister of Health were required to consent. For mentally retarded persons, the consent of the patient or his or her guardian was not required. Sterilization of persons in the other three specified categories required the personal consent of the patient.

The problems with this legislation become clear when we investigate the positions of the groups who pressured for its repeal. The geneticists were concerned that many of those sterilized did not in fact have a genetically transmissible disorder. The law societies urged repeal, arguing that involuntary sterilization constituted a violation of human rights — the *no consent* clause being the specific issue. The government itself was concerned because of the possibility of a proposed provincial Bill of Rights being inconsistent with non-voluntary sterilization. The Blair Report,[68] written at that time noted two kinds of practical problems with the old Act — provisions and implementation. One apparently faulty provision was the failure to require the appointment to the Board of those most appropriately specialized by discipline, training, and expertise. In terms of implementation, sponsors (chiefly provincial hospitals and clinics) of cases before the Board seldom provided extensive case data on genetic, social, psychiatric, psychometric, general medicine, or developmental background.[69]

The Act was repealed in 1972.

The British Columbia Eugenics Board was made up of a psychiatrist, a judge and a social worker. The provision for a sterilization[70] decision was an unanimous decision by the Board ". . . that procreation by the inmate (of a provincial institution) would be likely to produce children who by reason of inheritance would have a tendency to serious mental disease or mental deficiency".[71]

Although this was a much narrower provision than the Alberta statute, similar problems arose. No geneticist sat on the Board, and even if a specialist in the area were consulted, he could only have given the probability of a child's inheriting the mental handicap of his or her parent, while the statute used the term "likely".

Operations performed under the British Columbia legislation required the consent of the patient if he was deemed capable of giving that consent. If the patient was not deemed capable, the consent of the spouse, parent, guardian, or the Provincial Secretary was necessary.

The medical practitioner performing the operation was statutorily granted relief from civil liability. This law was used much less often than the one in Alberta, and was repealed in 1973. Generally the medical people felt that such an operation was unnecessary given the number of other forms of birth control available.[72]

One of the principal problems with such legislation was, according to McWhirter and Weijer,[73] that it "reflect[ed] legislated biases towards certain medical syndromes which, according to the legislators of 1928 and later of 1942, seem to qualify for sexual sterilization". Further, as Dr. Margaret Thompson, a former member of the Eugenics Board of Alberta wrote: "though theoretically the idea was laudable, the practical difficulties were very great because the approach of 'early eugenists' reflected their personal biases as to which characteristics were desirable and which were undesirable".[74]

(iii) *Sterilization to relieve the economic burden of dependency*

It has also been argued that society simply cannot afford the cost of long-term care and social services for the mentally handicapped and their offspring who may need the same care. This economic argument is summarized in the following statement:

> As our society becomes more technologically sophisticated and demands more and more freedom from discomfort, the production of

each individual and the benefit-to-cost ratio of each expenditure becomes increasingly important. On this scale, the mentally [handicapped] are in direct competition for personnel and funds with [other] programs . . .[75]

In its simplest form, the argument is that the determination of societal priorities must be based on a cost-benefit analysis. Therefore if certain persons (or groups of persons) place a financial burden on the state that is greater than the benefit they provide, then the state can justifiably establish policies to reduce those costs. One method of relieving such an economic burden is for the state to decide who will or will not be allowed to reproduce.

There is a further and somewhat less direct argument that has arisen in relation to economic burden. Regulationist proposals have been put forward advocating sterilization as a mechanism of population control. One of the key questions is obviously how best to decide who should not have or should stop having children. The tendency in such arguments has been to assume that the selective implementation of population controls should be based on societal contribution. The groups that have generally been spotlighted on that basis have been the handicapped and those on welfare. The utilitarian rationale for population control has been seen to be tied up with a drain on specific resources and not as a general problem.

Proposals to regulate reproduction in order to limit population face a number of objections. The absence of public policy in this area is probably the most compelling argument against the implementation of such proposals at the present time. Further, even if it were determined that a policy should be developed and government incentives or disincentives to reduce the overall population size should be implemented[76] and questions about the rights of individuals to privacy and self-determination could be solved, a number of factors would have to be taken into account in determining which form of policy to adopt.[77] Particular emphasis would have to be directed to ensuring that a limitation on population was not simply a thinly disguised mechanism of *qualitative* population

control. To guarantee that this did not ensue, a population control program would have to be structured to apply uniformly to all citizens, having taken into account all the social, economic and ethical factors.

In any event, a clear distinction must be drawn between limiting the population and preventing prospective parents from having any children. Although some persons have mistakenly confused these two positions in advocating the sterilization of certain groups, it seems unlikely that under close scrutiny, any serious weight would be given such an argument.

B. Benefits to the Handicapped Themselves

Proponents of non-consensual sterilization claim that there are four benefits to the retarded themselves. They include therapeutic reasons (which would be similarly applicable to the non-handicapped); removal of the threat of parenthood with which the mentally handicapped may be unable or unprepared to cope; inability of the mentally handicapped to bear the financial burden that accompanies rearing children; and for reasons of personal hygiene.

(i) *Therapeutic reasons*

These involve sterilizations performed to protect the physical health of the patient. There are three general categories of physical conditions that make sterilization medically advisable.[78] First are diseases which make a pregnancy dangerous to the life and health of the mother. This would include such conditions as severe cardiac or kidney disease. Second, there are diseases of a congenital or hereditary nature that make it probable that a pregnancy will result in still-born or severely and incurably deformed children. Finally, there are cases of frequent pregnancies which increase the probability of complications with subsequent births. This would include, for example, a series of prior births by caesarian sections.

(ii) *Inability to parent*

Another reason advanced for non-consensual sterilization of the mentally handicapped is their supposed inability to raise children. Such arguments are raised both with respect to societal concerns and with respect to benefits to the retarded themselves.

Within the context of societal good, the arguments advanced are similar to one that is raised by proponents of eugenics. It is held that society has the right to protect itself from being swamped by mental illness, mental retardation, crime, poverty and other social ills, and the high financial costs of these conditions.

Unlike the eugenists, however, who argued that the prevention of procreation was necessary because children of mentally handicapped parents would have the same conditions, by reasons of heredity, this school of thinking maintains that the children will have mental handicaps because of parental social inadequacies.

Sterilization is justified on the basis that mentally retarded and mentally ill persons make poor parents, that poor parents tend to produce children prone to crime and other social problems, and that to prohibit procreation by these individuals is an act of protection against this eventuality by not placing the responsibility of parenthood upon those unable to cope with it.[79] This argument presumes a state interest in ensuring that children receive sufficient care and attention to develop normally. This concern is both moral and economic.

Generally *fitness for parenthood* has been assumed to refer to the ability to provide for the physical, intellectual and emotional development of the child. The Royal Commission on Family and Children's Law in British Columbia[80] recommended that eligibility for artificial insemination should be the same as for adoption. "Eligibility of a potential recipient of artificial insemination should take into account her qualities as a prospective parent. A test of 'ability to nurture' should be developed by which to judge such variables as her emotional

and social qualities as a potential parent.''[81] Such guidelines have not yet been developed, and thus ability to nurture is a value-laden speculative process.

A parent's ability to provide for a child's intellectual growth is often presumed to decrease with that parent's decreasing intellectual ability. Intellectual ability is also correlated with an ability to provide for a child's physical care. The assumption is that a parent of severely diminished intelligence might not be capable of providing a safe environment for the child. Green and Paul[82] concluded that retarded parents showed fondness and concern for their offspring, yet the children suffered from neglect and deprivation. The neglect stemmed from inability to cope rather than from an unwillingness to provide the necessary care.

It has also been argued that sterilization liberates the mentally handicapped person to be involved in sexual activity. The corollary to this is the presumption that not to sterilize will involve prohibitions against sexual relations. Since sexual expression is important for all persons, whether or not they are mentally handicapped, sterilization is argued to be beneficial because it enables sexual activity. This is a tautologous argument however. Although it may be the case that restrictions on sexual activity are placed on mentally handicapped persons who are not sterilized, such a practice does not justify sterilizing such persons.

Finally, it is argued that frustration might result from the retarded parents' attempts to deal with a developing child and that it would benefit the parent not to be put in this situation.[83] Therefore there is a direct benefit to retarded persons not to be put in a position of having to cope when they are unable to do so.

(iii) *Inability to handle the financial burden*

Proponents of arguments relating to inability to manage financially say that the cost of bearing and rearing children is

compounded for the mentally handicapped arising from the fact that the overwhelming majority of such persons live on welfare or work at low-paid jobs. Some people have argued that without children the handicapped are able to make ends meet and can cope within the community, whereas they are unable to handle child-rearing responsibilities, so that in some cases they may have to return to institutional care. The additional financial burden of children on top of already existing economic problems may become the triggering factor for other psychological or emotional adjustment problems and may impair the ability to cope.[84] The solution that is presented is to remove the possibility of childbearing in those circumstances where a person does not have the financial ability to cope with children.

(iv) *Personal hygiene*

A case is sometimes put forward that because of an individual's inability to look after the hygiene that necessarily is involved with menstruation, a complete hysterectomy is beneficial. This it is argued relieves the additional burden of care placed on those responsible for such a person, as well as reducing the unsanitary personal hygiene that may accompany this inability. Some arguments have even been made that a hysterectomy performed for reasons of personal hygiene is beneficial to the individual because the time and energy that would be invested in training personal hygiene could be used for training in other skills. There are some obvious problems establishing that the benefit to the patient is great enough in such a circumstance to warrant such a major intrusion on the person. It is likely however[85] that if a person requires a great deal of assistance in managing their own menstruation, they are also likely to require assistance with urinary and fecal control, problems which are much more troublesome in terms of personal hygiene. The beneficial nature of the hysterectomy solely for hygenic purposes is therefore put in question. It is also possible, although it may raise a set of medical dangers as well as ethical and social issues on its own, to control the menstrual flow through the use of oral contraceptives.

C. Benefits to Future Generations

> My husband and I had to decide about our (retarded) son's future. We were told that he might very well have a normal child but that the child would never have a normal father. We felt that the child would be cheated in life, and we had him undergo a vasectomy.[86]

This argument for sterilization maintains that the children whose birth would be prevented by sterilization would be spared an uncertain rearing and future in which they might become as dependent as their parents.[87]

This line of reasoning also assumes that parental responsibility extends beyond normal child-rearing duties to include the duty to avoid bearing children with serious genetic defects, as far as possible.[88] It is argued that it is a *morally* irresponsible act for a parent to conceive and knowingly bear a child with genetic defects. Additionally, it is an irresponsible act to bear a child who will not have an opportunity to develop normally because of parental incapacity. Every child has a right to reasonable mental and physical health, the right to a good mental life, and the right to be free of genetic defect.[89] The parents (and society) are accountable to their children for their children's welfare and their potential children's welfare.

It is on the basis of these arguments that non-consensual sterilization is proposed. The validity of the assumptions will be examined in the next section where we will look at the arguments of those who oppose non-consensual sterilization.

2. Dangers of Non-consensual Sterilization

The dangers[90] of non-consensual sterilization are not only of a scientific, but also of a socio-political nature. The individual and social costs of sterilization of the mentally handicapped will be examined under the general categories of genetic fallacy, socio-political problems, psychological effects and human rights infractions.

These arguments address themselves not only to the particular issue of sterilization but to the more general issue of the place of law in moral/ethical decision-making and the manner in which a law which, in fact, is based on inconclusive scientific findings (that is which incorporates unproven hypotheses) may result in the unwarranted belief that such scientific findings are well founded. In that way the assumptions become not only legal fact but also become part of social mythology. The law may thus be based on myth or conjecture rather than valid scientific or social knowledge. In the case of sterilization this has resulted in a continuing effort to justify existing statutes and practices by replacing the presumed scientific bases as they have been found to be incorrect, questionable or unjust. The arguments have changed in this way from genetic considerations to parenting ability and economic reasons. The rationale for the law has therefore evolved after the fact. The result has been a defensive stance whenever sterilization of the handicapped has been undertaken, creating confusion as well as some backlash against the practice.

A. Genetic Fallacy

The scientific arguments against non-consensual sterilization were summarized in 1960 by Dr. Bernard L. Diamond when he served as a special consultant to the American Psychiatric Association for its report on mental health legislation in British Columbia:

> [A]ll laws providing for the sterilization of the mentally ill or defective which have as their basis the concept of the inheritability of mental illness and mental deficiency are open to serious question as to their scientific validity and their social desirability.
>
> Laws of this type followed logically from prevailing psychiatric concepts of the late 19th and early 20th centuries, in which mental illness, be it psychosis, psychoneurosis, or mental deficiency, was regarded as inherited deficiencies or weaknesses. Particularly in relation to mental deficiency, the development of fairly precise tests of intelligence, such as the Stanford-Binet test, promulgated the idea that intelligence was a fixed attribute of the individual and was primarily determined by genetic factors. Legislative bodies were impressed by lurid clinical descriptions of the Jukes and the Kallikaks — families in which antisocial behavior or mental deficiency recurred in generation after generation.

> Present day psychiatry, although still vitally interested in the possible genetic factors in mental illness and mental deficiency, avoids the sweeping generalizations so prevalent in the past. Genetics has evolved into a much more precise science and very significant work is being done on the inheritance of mental illness. Nevertheless, this is a field of great conflict: there has been much learned in recent years of the impact of environment on child development; of the essential role of the psychodynamic factors in personality development and production of mental illness; and of the susceptibility of the child *in utero* to unfavorable metabolic and infectious conditions of the mother.
>
> In short, the present state of our scientific knowledge does not justify the widespread use of the sterilization procedures in mentally ill or mentally deficient persons . . .
>
> It is sometimes proposed that sterilization is demanded, irrespective of the uncertainties of our knowledge of heredity, in that a mentally ill or feebleminded person is incapable of providing the emotional and material environment required to raise a normal child. Perhaps this is so, but it raises issues of a sociological and political nature of a very uncertain character and it may be most dangerous to apply such sociological concepts under the guise of a genetic thesis that is far from proven and highly uncertain in its application.[91]

The argument against non-consensual sterilization of mentally handicapped persons based on genetic rationale is simply that there is not enough scientific evidence to support the practice on this basis. The impact of sterilizing the mentally handicapped as a method of reducing the proportion of genetically defective persons, notwithstanding Justice Holmes' statement,[92] is very limited. To have a significant impact on the proportion of mentally handicapped in the population would require much more wide-reaching measures, including substantially broadening the categories of persons being prohibited by society from having children.

In the historical analysis[93] of social forces affecting the decline of the early eugenics movements (in the 30's and 40's), two principal factors have been cited. First, as early as 1915 genetic research began to suggest that inheritance was much more complex than previously assumed. The ability to rapidly eliminate undesirable traits from the population was shown to be scientifically questionable. Also, the separation of heredity and environment began to be challenged, undermining one of the basic assumptions of the eugenics movement. Many geneticists withdrew from the movement at this time because

of what they considered the uncritical over-extensions of genetic principles to eugenics programs. Factors outside the science of genetics also led to the erosion of scientific support for eugenics programs. In particular, the application in Nazi Germany of widespread eugenics policies with no consideration of their ethical and social implications provided the basis for scientific withdrawal from the movement, as well as public condemnation of such excesses.

The American Neurological Association in 1936 made the following arguments in response to the advocates of eugenic sterilization:

- There is nothing to indicate that mental disease and mental defect are increasing, and from this standpoint there is no evidence of a biological deterioration of the race.

- The reputedly high fecundity of the mentally defective groups . . . is a myth based on the assumption that those who are 'low' in the cultural scale are also mentally and biologically defective.

- Any law concerning sterilization . . . under the present state of knowledge [of heredity] should be voluntary . . . rather than compulsory.

- Nothing in the acceptance of heredity as a factor in the genesis of any condition considered by this report excludes the environmental agencies of life as equally potent, and in many instances as even more effective.[94]

In 1937, a committee of the American Medical Association reported: "Our present knowledge regarding human heredity is so limited that there appears to be very little scientific basis to justify limitation of conception for eugenic reasons . . . There is conflicting evidence regarding the transmissibility of epilepsy and mental disorders."[95]

It was not until the 1940's that new scientific interest was rekindled with the discovery of the genetic basis of a large number of diseases.

To understand the scientific fallacy of sterilization as a method of reducing hereditary mental handicap we have to look at the way in which heredity operates.[96] Since no indis-

putable scientific evidence about the genetic transmission of mental illness has been found,[97] we will restrict this discussion to mental retardation, where in some cases concrete evidence of hereditary links have been documented.

As has already been pointed out, the causes of mental retardation may be divided into three categories: genetic factors, a combination of genetic and other factors and factors that do not relate to genetics. With the purely genetic causes, (*e.g.* Tay Sachs Disease[98]) some are transmitted by a dominant gene and some by a recessive gene. In other cases the defect, though genetic, requires the influence of other factors to produce the mental retardation (*e.g.*, phenylketonuria (PKU)). Finally, mental retardation may result solely from non-genetic factors (*e.g.*, trauma and meningitis can cause brain injury and mental retardation). As well, an impoverished intellectual or emotional environment may stunt mental growth and development.

An examination of mental retardation resulting solely from genetic factors requires taking into account the significance of both recessive and dominant genes in inheritable mental retardation.

When mental retardation is attributable to a dominant gene, the risk of mental retardation in children is fifty percent. Since the mentally retarded parent carries at least one defective gene and since it is dominant, the gene and hence mental retardation will appear *statistically* in at least half the offspring.

A recessive gene results in mental retardation only in persons who are homozygous; that is, only when both genes governing the characteristic are defective will the child be mentally retarded. If a person affected by mental retardation caused by recessive genes marries a non-carrier, the children will be heterozygous; that is, they will carry the gene but not manifest the trait. But if both parents carry a recessive, defective gene, there is a twenty-five percent chance that a child will be mentally retarded while fifty percent of the offspring will be carriers of a recessive gene and be unaffected. If one

parent carries the recessive gene (both parents being normal) there will be a twenty-five percent chance of one child being a carrier of the recessive gene.

Because females have two X-chromosomes and males only one X and a Y chromosome, there are some differences in sex-linked inheritance patterns. The characteristics of diseases showing X-linked recessive inheritance are: "(1) the disease appears almost always in males, whose mothers are apparently unaffected but heterozygous carriers of the mutant gene, (2) each son of a carrier female has a 1:1 chance of being affected, (3) affected males never transmit the gene to their sons, but they transmit it to all their daughters, who will be carriers, (4) unaffected males never transmit the gene."[99] The usual pattern is therefore for the gene to be transmitted through unaffected females and to be manifested in males.

The logic of applying statutes to broad classes of mentally retarded persons without regard to the dominant or recessive character of the defective gene or the fact that only certain forms of mental retardation are genetic at all is then obviously faulty.[100]

Therefore even if the scientific evidence of hereditary defects were conclusive, an effective programme of control would have to rely on an ability to identify the groups carrying defective genes. Some people have estimated that eighty-nine percent of all inherited mental deficiency is transmitted by persons who are not themselves affected.[101] These outwardly normal carriers cannot be readily identified. The result is that even if all the mentally handicapped could be sterilized (which would be impossible since such a large proportion never comes to the attention of authorities or agencies), there would be an (approximate) eleven percent reduction in mental handicap in the following generation. Obviously, the enormity of such a sterilization program prohibits it in any event, but for such a program to be effective, it would require the sterilization of all carriers of genetic abnormalities who are phenotypically normal as well as those who are themselves so handicapped. "It has been estimated that the normal carriers are from ten to thirty times more numerous than the affected

persons . . . [so that] this would involve the sterilization of . . . at least ten percent of the population."[102]

There are other factors that affect the transmission of genetic disease. The probability of biological sterility is high in many cases of mental retardation,[103] and many persons born with such conditions do not reach the age of puberty. In addition, in cases of moderate or severe retardation, the sex drive may be reduced and social isolation could be a result of the handicap.

Finally a number of scientists have argued that in eliminating undesirable genetic traits, some genetic elements essential to human survival may also be eliminated.[104] Briefly, the assumption is that the balance of a species is dependent on a composite of heterogeneous conditions. Thus the genetic compositions of all persons, including those with mental or physical deficiencies, are important to the future survival of the race.

As one expert has put it: "subnormal mentality must inevitably result from normal variation 'and the genes carried by the fertile scholastically retarded may be just as valuable to the human race, in the long run, as those carried by people of high intellectual capacity'."[105]

It is extremely difficult, if not impossible, to isolate the factor or factors that may be causing an individual's mental handicap; the etiology more likely being a combination of mutually reinforcing factors. The impact of eliminating identifiable genetic causes will not be great enough to justify the social, political, and psychological costs of the procedures necessary to accomplish that goal.

Meyers, having examined the rationale for eugenic sterilization concluded that:

> In man's present state of knowledge, it is submitted that such treatment of any individual is only medically and morally justified when carried out pursuant to his free, uncoerced request, once the full implications of the operation have been brought home to him as to those persons closest to him and responsible for his welfare.[106]

B. Socio-political Consequences

> To examine further the arguments advanced by the proponents of eugenic sterilization is to find the mistaken zeal of the reformer, disregard for people as individuals, no understanding of social phenomena, advocacy of class discrimination, and finally, even racism of the worst kind. The attitude towards people is a patronizing one.[107]

The criticisms that have been aimed at policies of sterilization on the basis of its socio-political consequences are particularly severe. Some writers have maintained that in fact the ramifications are so profound that the medical/genetic reasons given may be little more than justifications for rationalization of an institutionalized form of genocide against certain groups. Whether or not we accept such a machiavellian interpretation, it is of utmost importance to examine the effect of such laws and the use of science to justify them.

The operation of the Eugenics Board of Alberta clearly indicates the divergence between the intent of a law and its effect. An examination of the implementation of that law[108] demonstrates the socio-political problems that can arise. The data presented give a clear indication of the inequitable application of law that can unintentionally result even when objective criteria are supposedly being used.

In the period of the administration of the law (1927-1972), it was used as an authority to sterilize some 2,500 persons. In addition to those who actually underwent sterilization surgery, there was an additional group who were approved by the Board for sterilization, although they did not undergo the surgery. In a study of the operation of the Board by Tim Christian,[109] these categories were used to distinguish differences between approval of, and actual sterilization as carried out under the law.

Of patients approved for sterilization 40.9% were male and 59.1% were female. Of the patients ultimately sterilized 35.3% were male and 64.7% were female. Thus, not only did the Eugenics Board approve the sterilization of more females, but a disproportionately high number of them were sterilized.

Christian suggests that the reason for this discrepancy was related to the fact that the grounds *incapable of intelligent parenthood* were applied only to female patients recommended for sterilization.

Under the law, a disproportionately high percentage of children were presented for sterilization. Children approved for sterilization by the Board were more likely to be sterilized than adults similarly approved. The reasons suggested by Christian are:

> First, children who were presented and approved were more likely to have been diagnosed as mentally deficient than psychotic or schizophrenic and hence, after the 1937 amendment . . . could be sterilized without prior consent having been obtained. Second, even in cases where consent was required before a child could be sterilized, the approval of the parents or guardian were sought. In such instances the parents or guardian were likely prepared to accept the opinion of the panel of experts that constituted the Eugenics Board and that apparently had the best interests of their child as a primary concern. The families of those children diagnosed as mentally deficient were also relieved to be rid of the burden of a potential pregnancy. In many cases, the initiative for sterilization came from concerned parents — particularly those who were unable to cope with their daughters' beginning menses.

Evidence regarding occupational categories indicated that the number of sterilizations of those *not employed* was comparatively high and the proportion of *domestics* sterilized was very high. On the other hand, none of the *professionals* presented to and passed by the Board was sterilized.

Figures on residency characteristics show that institutionalized persons were much more likely to be sterilized than other persons. In effect, sterilization became a condition of release from hospitals for mentally defective children. This practice was made possible by the discretionary authority of institution superintendents to approve or deny releases and the duty imposed on the superintendents to safeguard the interests of both the patient and the public.

In his examination of the religious affiliation of the persons dealt with, Christian found that:

> . . . a disproportionate number of persons of Roman and Greek Catholic faith, compared to their numbers in the Alberta population, were recommended for surgery and actually sterilized.

The differential treatment accorded to persons of different ethnic backgrounds throughout the period of the *Sexual Sterilization Act* is perhaps the most striking finding in Christian's statistical analysis. In all time periods, he found a disproportionately small number of persons of British and West European ancestry presented to the Board or approved for sterilization. Moreover, a disproportionately low number of *British* citizens were actually sterilized. The opposite situation was found for persons of East European and Indian or Métis ethnicity. Their numbers were disproportionately high both in their being presented to the Board and their being approved for sterilization. Christian points out another interesting discrepancy in the period 1939-1943 between the percentage of persons of East European ancestry approved for sterilization and the percentage actually sterilized:

> Although citizens of East European ethnic background constituted only 15.4% of the population of the Province, they constituted 29.7% of the population of patients presented to and approved for sterilization by the Eugenics Board, and they constituted 35.1% of the population actually sterilized.[110]

The differential treatment of Indians and Métis under the Act was even more striking:

> In every time period, a disproportionately large number of native people compared to their numerical significance in the Alberta population were approved for sterilization . . . and actually sterilized. The most extreme discrepancy occurred during the last years of operation of the Board. Although persons of Indian or Métis ancestry constituted a mere 3.4% of the Alberta population, they constituted 25.7% of those persons sterilized. It is incredible that between 1969 and 1972 more Indian and Métis persons were sterilized than British, especially when it is considered that Indians or Métis were the least significant racial group, statistically, and British were the most significant.[111]

Christian suggests that the discriminatory practices of the Board mirrored prevailing public attitudes of the time. The federal immigration policies after World War I reflected an anti-East European bias, and the manifestation of the same attitudes towards this group by the Eugenics Board is not viewed as surprising.

> In view of the prevalent, chauvinistic, resentment focussed on non-British, non-West European residents of the province, and in view of

> the diagnostic methods employed by Alberta psychiatrists . . . it seems a reasonable conclusion that racial bias was a significant factor in the sterilization of East European patients.[112]

Mr. Christian sums up his findings and his interpretation in the following manner:

> Persons presented to and approved for sterilization by the Board occupied socially vulnerable positions. They tended to be female rather than male, young and inexperienced rather than mature, not employed and dependent rather than self-supporting, employed in the low status rather than prestigious jobs, residents of small towns rather than cities, members of ethnic minorities rather than the dominant ethnic group, single rather than married, and had been defined as sexual deviants. In addition, those persons dealt with by the Eugenics Board had been branded with the most socially debilitating label of all — a psychiatric diagnosis.[113]

In light of these findings it is important to look at the processes whereby the acceptance of intelligence became legitimized as the criterion for social worth and a rationale for sterilization.

The development of relatively safe and easy methods of sterilization, as well as the development of intelligence tests, in the late nineteenth and early twentieth century resulted in *scientific* standards for determining who was unfit and *scientific* procedures to ensure that such persons did not reproduce. In his development of the "survival of the fittest" concept, Herbert Spencer emphasized intelligence and technological innovativeness as essential criteria for explaining the natural selection process. Thus, supposedly scientific criteria were used to judge as *unfit* those who were already considered *inferior*.

From principle to practice, breeding was then to be restricted to those who were defined as physically, mentally and morally sound. Further, it was argued that if such restrictions were not imposed there would be an excessive increase in the degenerative elements in the population, both because the undesirable, defective gene pool would be increased and because people who were physically, mentally and morally *unsound* had higher reproductive rates (originally Spencer's idea) and so would outpace the *desired* population elements. Given

that society should assume responsibility for the maintenance (usually in institutions) of such persons, any increase in this population would necessarily impose a burden on the public purse.

The fear of vastly higher reproductive rates cannot be substantiated by fact. A number of comparative studies have shown that the procreation rates of the mentally retarded and control groups are not dissimilar, as can be seen in table on page 47. In other words, mildly retarded adults appear to have no fewer, but probably not significantly more children than the average.

The institutionalization of mechanisms of population control[114] has taken a number of forms. Population control does not simply limit the number of persons born but also the *kind* of person born. If a law says that mentally handicapped persons in state-run institutions may be sterilized without consent or with third party consent, the law sounds equitable enough. But the assumption on which that is based is that all mentally handicapped persons are equally likely to be institutionalized and that all persons are diagnosed as being mentally handicapped in the same way — that is, that objective criteria exist by which to determine mental retardation and illness. It also assumes that the causes of these conditions are known. The questionable nature of these assumptions has already been pointed out. How is it then that such laws have existed and do exist, and why do some people call for the expansion of *quality-control* on population to others such as welfare recipients?

There are a number of explanations. First, the arguments in favour of sterilization have been presumed to be both scientifically valid and socially acceptable. The eugenic rationale, the unfitness-to-parent rationale, and intelligence tests have all been presumed to be supported by *scientific* data, and although much of the data has also been scientifically disproved, new variables have been substituted as proof of the validity of the hypotheses. I.Q. tests have been a matter of controversy and, as we showed earlier, can be attacked on a number of grounds. Again with *fitness-to-parent* the criteria used to measure that ability are not reliable. We do not generally assume

Marital status of retardates as reported in selected follow-up studies

Name of study and characteristics of retardates	Married, living with husband	Never married	Other	Number of children divided by number of retardates ever married
Fairbank study				
Subjects: Males	50.0%	33.3%	16.7%	1.1
Females	70.0	4.0	26.0	1.8
Controls: Males	50.0	47.5	2.5	1.2
Females	50.0	38.0	12.0	1.2
Kennedy study				
1948				
Subjects: Males	44.7	52.8	2.5	1.3
Females	54.6	41.2	4.2	1.6
Controls: Males	40.0	58.8	1.2	1.4
Females	49.0	49.0	2.0	1.5
1960				
Subjects: Males	81.7	13.0	5.3	2.1
Females	73.4	15.6	11.0	2.1
Controls: Males	83.7	9.1	7.2	2.1
Females	80.9	10.6	8.5	2.2
Baller study				
1935				
Subjects: Males	33.3	n/a	n/a	1.3
Females	58.9	n/a	n/a	1.4
Controls: Males	52.4	n/a	n/a	1.3
Females	59.0	n/a	n/a	0.7
1951				
Subjects: Males	72.6	21.9	5.5	2.0
Females	58.0	22.9	19.1	2.4
1964				
Subjects: Males	71.2	15.2	13.6	n/a
Females	54.7	20.8	24.5	n/a
Middle group				
Males	85.2	n/a	n/a	n/a
Females	80.7	n/a	n/a	n/a
High group (males & females combined)	90.0	n/a	n/a	n/a
Saenger study				
Males	2.0	98.0	0.0	1.0
Females	3.0	94.0	3.0	1.0

Conley, Robert W., *The Economics of Mental Retardation*, Baltimore: John Hopkins University Press, 1973.

that people have an inbred expertise to put on diapers, feed or even provide for the emotional needs of a child. These are generally learned experiences which are acquired after a child has been in the care of a new parent. If we measured *fitness-to-parent* by a criterion such as ability to stop a new-born from crying, most parents likely would be designated *unfit*. It may not be any less arbitrary to say that intelligence and socio-economic status can be used as predictive factors of ability to learn to be a fit parent. Empirical studies have shown that some persons with mild or moderate forms of retardation are able to fulfil the responsibilities of parenthood.[115] The presumption that mental handicap necessarily precludes the ability to parent cannot be justified. (Indeed, recent revelations about violence in the family and particularly child battering suggest that these phenomena are not unique to any specific sector of the population but cut across all economic and occupational groups.)

There are three identifiable processes by which these ideas were translated into the practice of non-consensual sterilization. First, the *scientific* facts convinced the public of the morality of the action. There was public pressure to do something based on the widespread social belief that the mentally handicapped were a threat to the gene pool, an overwhelming financial burden, and a danger to the well-being of children (children are a motherhood issue on which much public pressure can be incited). Cochran[116] refers to the removal of the right to make procreative choices from the retarded as an elitist fright. He argues that it reflects a fear of sexuality, a fear of the difference which is called inferiority and a fear for the quality of the species, and suggests that such fear in turn spawns hatred of races, classes and social categories — a basis for public pressure to reduce the numbers of such people in the population.

Secondly, in conjunction with those societal beliefs, individual families often suffer from the guilt associated with having a handicapped child. Because they feel responsible for the handicap and the need for services for their child, and are the victims of irrational fears from other members of the community, it is hardly surprising that parents might agree to in-

stitutionalize such children. Because of such stigmatizing, they *consent* on behalf of their children or relative to sterilize their children. The same stigma results in the mentally handicapped individual defining himself as having less social worth and being less capable of rearing children. On this basis such a person is more liable to consent to a procedure such as sterilization. In studying the reactions of the mentally handicapped to sterilization, Edgerton[117] found that the situation became a double bind. Those who had been sterilized defined themselves as different from (and not as good as) other people. Being sterilized was then seen as tangible evidence of being less capable.

As a result, the idea that intelligence and social worth are synonymous has been entrenched even further. This idea has legitimized beliefs about the ability to parent being related to socio-economic status. It has justified the idea that society cannot *afford* certain types of people, that social deviance can and should be reduced. It has further eroded the notion of societal responsibility for conditions that lead to mental retardation and mental handicap. It has resulted in class and racial biases. Finally, it has changed the concept of medical treatment from prevention (and cure) of the disease to prevention of the person.

C. Psychological Impact of Sterilization

Some researchers who have carried out psychological studies in this area argue that one of the potential psychological effects of sterilization when done without personal consent is the definition of self as deviant and as unworthy of the rights of parenthood.[118] They maintain that on this basis alone such a procedure should never be carried out without an informed consent. Such a self definition is often linked with the denial of a variety of other rights.

Until recently it was generally assumed that mentally handicapped persons did *not* react negatively to sterilization. Since much had been written about the adverse psychological impact on the non-handicapped,[119] it can be inferred that the

reason the effect on the handicapped would be considered to be different was the perception of such persons as *non-human* or less human than other people. The mentally handicapped were thought to be unable to express or understand their feelings towards sterilization.

Chez[120] argues that the individual patient characteristics, the source of the initiation of the request and the perception of the disease all play critical roles in the patient's subsequent tolerance and satisfaction with temporary or permanent control of conception.

The assumption that mentally handicapped persons are unable to understand and express their feelings towards sexuality, parenthood and sterilization has been clearly discredited by recent research and by recent reports of direct work with the mentally handicapped.[121] It has been found that, like anyone else, the mentally handicapped have individually varying reactions to sterilization. Sex and parenthood hold the same significance for them as for other people and their misconceptions and misunderstandings are also similar. Rosen[122] maintains that the removal of an individual's procreative powers is a matter of major importance and that no amount of *reforming zeal* can remove the significance of sterilization and its effect on the individual psyche.

In a study by Sabagh and Edgerton,[123] it was found that sterilized mentally retarded persons tend to perceive sterilization as a symbol of *reduced* or *degraded* status. Their attempts to *pass for normal* were hindered by negative self perceptions and resulted in withdrawal and isolation rather than striving to conform. In fact this effect may bring a greater dependence on the state and so refute the economic arguments in favour of sterilization.

The psychological impact of sterilization is likely to be particularly damaging in cases where it is a result of coercion and when the mentally handicapped have had no children.[124]

> Existential anxieties, commonly associated with mental retardation are likely to be seriously reinforced by coercive sterilization of those who have had no children. Common sources of these anxieties include low

self-esteem, feelings of helplessness, and need to avoid failure, loneliness, concern over bodily integrity and the threat of death.[125]

A number of basic assumptions about the ability and potential of persons with mental handicaps underlie the psychological arguments against involuntary sterilization. They hold that such persons have the same uniqueness and variety as others, so that their reactions to experiences are no more or less likely to be uniform than the reactions found in the rest of the population. This view is based on a developmental model of persons with mental handicaps, which posits substantial potential for growth and development, and therefore encourages opportunities to increase their freedom of choice and to develop full human potential.

This approach concurs with the notion of *normalization* which is the basis of innovative programs for the mentally handicapped now being developed in Canada.

Normalization,[126] has been defined as:

> . . . [the] utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible.[127]

Wolfensberger, the author of this particular definition, intended the term *normative* to have "statistical rather than moral connotations and [to be] equated with 'typical' or 'conventional'. The phrase 'as culturally normative as possible' implies ultimately an empirical process of determining what and how much is possible."[128] The definition in these terms thus implies both a process and a goal while not assuming that all persons will thereby become *normal*. This is an important distinction because it clearly views the clientele from a socio-developmental perspective and not within a medical model.[129] The principle:

> . . . does imply that in as many aspects of a person's functioning as possible, the human manager will aspire to elicit and maintain behaviors and appearances that come as close to being normative as circumstances and the person's behavioral potential permit; and that great stress is placed upon the fact that some human management means will be preferable to others. Indeed, sometimes a technique of less immediate potency may be preferable to a more potent one,

because the latter may reinforce the perceived deviance of the person, and may be more debilitating than normalizing in the long run.[130]

Implementation of this principle would accord to the mentally handicapped the same opportunity to marry, have children, and elect to be sterilized as is accorded to other citizens. This does not presume that all mentally handicapped persons are uniformly capable of undertaking these responsibilities or that they would even want to, but merely that as far as they are able they should be granted the opportunity.

Psychological reactions to sterilization are compounded when the choice of procreation for an individual has been made by the state rather than the individual. Therefore it is argued that whatever action is taken must be individualized, and the particular needs of each person must be taken into account to ensure that the psychological and social advantage outweighs the psychological damage.

D. Denial of Human Rights

Some critics[131] of sterilization maintain that the rights of the mentally handicapped are being not only compromised but denied when sterilization is performed without the consent of the individual. Proponents of this argument maintain that such a procedure infringes on an individual's right to procreate, to security of the person, and to equality before the law. Furthermore, such a procedure constitutes unjustified discrimination and the denial of the presumption in favour of the retention of all rights unless specifically taken away.

Although a right to procreate is not expressly recognized in Canadian law, Canada was party to the adoption of international agreements that recognize such a right. The moral and political obligations of such agreements should influence Canadian policy in this area. Two of the international agreements that imply the assurance of procreative rights are the Universal Declaration of Human Rights[132] and the 1968 Proclamation of Teheran.[133] The latter document enunciates a basic human right of parents to determine freely and responsibly the

number and spacing of their children. Persuasive English case law has similarly considered reproduction a basic human right.[134] It may be maintained, therefore, that all persons, including the mentally handicapped, have a right to be free from involuntary sterilization as well as the freedom of choice to be voluntarily sterilized.

The *Canadian Bill of Rights* ensures that all persons shall be treated equally before the law.[135] Validly enacted federal legislation will likely not be in violation of the Bill of Rights if it seeks to achieve a valid federal objective.[136] In consideration of international obligations and the arguments advanced above (Section II (2)), it is arguable that a valid public interest for sterilization of the mentally handicapped could not be proven. If sterilization could be interpreted as protective rather than violative, this might not be so, since Canadian laws presently provide some protection for the mentally handicapped and these are not suggested to be contrary to public interest.[137] However, the presumption of sterilization as a protective measure cannot be easily justified, if at all. The only argument would be that it protects the liberty of the mentally handicapped person to participate in sexual acts that might be prohibited if he or she were not sterilized. Such a presumption would not be argued in cases involving a non-mentally handicapped person, and it is unlikely that the denial of a right to sexual expression could be more easily justified as a protective measure than sterilization.

The *Canadian Bill of Rights* further guarantees security of person and the right not to be deprived thereof except by due process of law.[138] This may be interpreted to mean that sterilization may not be performed on the mentally handicapped except according to the law of Canada. The *Criminal Code* presently provides that, at a minimum, physical intervention requires an individual's consent. The whole aspect of consent in criminal law, however, has remarkably not been sufficiently studied and capacity to consent is dependent upon the common law ability to understand the nature and consequences of an act. There is no other mechanism particularly applicable to mentally handicapped persons except, perhaps, as suggested in the 1975 United Nations Declaration of the Rights of Dis-

abled Persons. That document accords the same rights to handicapped persons as to other persons to the extent possible. It provides that:

> Whenever disabled persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the disabled person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

This declaration which was adopted, with Canada present, could provide minimum practical procedural safeguards should the security of a mentally handicapped person be deprived.

Increasingly, both federal and provincial human rights legislation prohibit discrimination based on physical disability[139] and mental deficiency.[140] Although it would be incorrect to suggest that sterilization based on mental handicap constitutes a discriminatory practice within the meaning of any Canadian legislation, there is a significant move towards obligatory non-discrimination based on disabilities beyond the control of an individual.

The preamble to the *Canadian Bill of Rights* expressly acknowledges the dignity and worth of the human person.[141] One of the common measures of worth is a person's ability to exercise the rights generally accorded in the society.[142] Any denial of rights is, therefore, likely to be interpreted as a reflection of a person's "worth" in society. A denial of rights to mentally handicapped persons not only reinforces the social stigma attached to the handicap but also denies the opportunity of such persons to prove that they are capable of handling the responsibility attaching to those rights.

The denial of rights to mentally handicapped persons can only be based on the determination of individual capacity to do specific things. The onus of proof of incapacity lies with those who advocate denying the mentally handicapped person's right to determine his or her own best interests. Proponents of civil rights arguments thus maintain that data must be

generated and criteria developed to predict that harmful consequences will result if such persons procreate, and, further, that these consequences are of greater harm than similar predictions for persons who are not mentally handicapped.

In summary, widespread sterilization of mentally handicapped persons has been opposed on the grounds that it discriminates against certain classes and races because the criteria for determining mental retardation and mental illness differentiate between classes and races; that it is difficult to determine equitably who should be sterilized because of the imperfections of intelligence tests and the lack of knowledge concerning the role of cultural deprivation in individual and familial deprivation; that there is doubt that anyone is qualified to make decisions about who should be sterilized; that sterilization will be used punitively; that sterilization is immoral and that individual rights and dignity have priority, in any case, over the societal benefits that would be derived from such a policy. There is also concern that the need for social services is being translated as a need for a sterilization program.[143]

All of these objections can be directed at any program aimed at categories of persons rather than at individuals. Assigning people to categories such as "mentally retarded" or "mentally ill" overlooks the fact that a policy that may be appropriate for some persons in a group may be entirely inappropriate for other persons in the same group. Since there is no scientific way at the present time of determining which persons within a group should be treated in which way, it is hazardous to create public policy in such a crude fashion.

> The paramount and critical issues here are not scientific but social. The questions which ought to be asked are questions of values not to be resolved under the microscope, but to be argued in the public domain.[144]

> Can involuntary sterilization which resolves so few genetic problems and creates so many more social problems, be considered an appropriate prescription?[145]

III

Can Sterilization Be Legal and Justified?

1. The Legality of Sterilization as a Medical Procedure

Sterilization as a surgical procedure is legally characterized as an intentional interference with the person. As such, the legality of sterilization is dependent on the fulfilment of the following criteria: informed consent, individual benefit, performance with reasonable care and skill, and lawful justification.[146] Potential criminal liability lies within the offences against the person, notably, assault,[147] causing bodily harm with intent,[148] and criminal negligence.[149] Civil liability may arise by way of assault, negligence, and breach of contract. For both criminal and private law, the legality of sterilization may ultimately depend on the purpose or circumstances of the intervention. Thus, it is expedient to consider therapeutic sterilization, eugenic sterilization, and contraceptive sterilization separately.

There is little doubt that therapeutic sterilization is lawful provided it is performed with the consent of the individual, with reasonable care and skill, and to preserve the life or health of the patient. "Health", for the criminal law means physical and mental health.[150] The concept of "mental" health is difficult to deal with within legal parameters and a variety of questions have been raised about the scope of its inclusive-

ness. Section 45 of the *Criminal Code* specifically provides that surgical operations will not be subject to criminal liability if they are performed for an individual's benefit, with reasonable care and skill, and are reasonable in the circumstances of the case including the health of the patient. In the absence of consent, it is likely that section 45 would provide justification only in situations of emergency or necessity, although there are views to the contrary.[151] The generally accepted view is as follows:

> Whether the primary purpose of the surgery is to sterilize or sterilization is an incidental result of the surgery, the medical necessity for the procedure places it within the arena of most other medical procedures.[152]

Under private law, therapeutic sterilization as a surgical operation is legal provided that it is performed with consent or in an emergency with or without consent if it is performed for the preservation of life or health and reasonable care and skill is exercised.[153]

The legality of eugenic sterilization, at least in criminal law, is less clear than for therapeutic sterilization. Kouri[154] outlined the problem in the following manner:

> The problem is somewhat accentuated from a criminal law view-point due to the fact that the general defence (concerning surgical operations) afforded by article 45 Cr. C. requires that the operation be performed 'for the benefit' of the patient, having regard *inter alia* '. . . to all the circumstances of the case'. Again one must ask, just how direct a benefit must be derived? With therapeutic sterilization, the saving of one's life or health provides the most immediate and direct benefit possible. In cases of eugenic sterilization, the benefit is not as direct since the mother (or indeed the family) is advantaged only by not being drained of the time, effort, expense, anxiety and heartbreak involved in raising a defective child.

Even if such an indirect benefit were to be subsumed in the interpretation of benefit, there would have to be some evidence that the future child was going to be "defective". Because "benefit" has not been judicially interpreted, its parameters are open to interpretation and speculation. There is some basis for considering the term to include emotional,[155] and "reasonable"[156] benefits that may extend so far as to cover familial and economic interests.[157]

The legality of eugenic sterilization is equally in doubt in private law. Recent Canadian and English cases are to the effect that the performance of non-therapeutic sterilization without consent is a violation of procreative rights.[158] Legal commentary is divided.[159] The situation is further complicated by the possibility of an action for «wrongful life» brought by an infant against a physician alleging that his failure to inform the parents of a possibly defective child was the proximate cause of birth which resulted in harm to the infant.[160]

The non-therapeutic nature of contraceptive sterilization may result in similar legal uncertainty. Although English case law has suggested that contraceptive sterilization may be contrary to public policy,[161] Canadian courts have indicated otherwise.[162] The Canadian view is further supported by the lifting of the ban on the advertisement or public sale of contraceptive information in the *Criminal Code* in 1968[163] and the broad public acceptance of contraception in general. Indeed, most legal opinion holds that the legality of such a procedure will be unquestioned provided it is performed on a fully informed consenting adult.[164] However, ambiguities and uncertainty as to the legal position may again result from the nature of the informed consent and the representations and warranties made to patients by physicians before performing the procedures. As well, the meaning of "benefit" to the person may be raised in the case of contraceptive sterilization. Although there has been discussion about the necessity of obtaining the consent of the spouse of the patient, it seems most unlikely that this is legally required.[165]

Although some doctors will perform eugenic or contraceptive sterilization with these legal uncertainties, the situation is far from satisfactory. This uncertainty has prompted legislative clarification in other countries. Swedish legislation acknowledges a woman's right to have herself sterilized for eugenic, social, medical, and medical-social reasons.[166] The Alternative Draft of the German Penal Code provides that sterilization is lawful if carried out by a doctor in accordance with medical standards, the person sterilized has consented, and either the sterilized person is over twenty-five years of age and has received counselling or the sterilization is for eugenic purposes.[167]

2. State Intervention in Sterilization

The legal uncertainties and the arguments both for and against non-consensual sterilization demonstrate the need to develop public policy in this area. It appears from what has preceded that the only purpose which may be legitimately served by state intervention in the procreative ability of the mentally handicapped is the benefit to the individual. Thus the state is protecting a person who is judged incapable of protecting himself.

Although some mentally handicapped persons are able to parent, there are others who are simply unable to cope with the responsibility. Therefore, it is argued that although there should be no general rule about compulsory sterilization, it should be possible to sterilize without *personal* consent in individual cases. Such a decision would be based on the psychological and financial burden that would be imposed on a person in the event they had a child. Being, almost by definition, part of the marginal labour force,[168] a mentally-handicapped person may be financially incapable of providing the physical necessities for a child.

Psychologically, it may be argued that the trauma of child-birth itself could cause severe stress. For this argument to be held valid would require that it could be demonstrated that the stress of delivery was greater in the case of mentally handicapped persons than it is for others. Considering the generally known wide range of post-partum response would likely render this a difficult case to prove. In addition the psychological strain of child-rearing may be argued to be the one additional factor that changes an individual's status from self-sufficiency to dependency. The adjustment to community life may be jeopardized by the need to care for a child. It is argued, therefore that the trade-off between being a truly independent member of society and being institutionalized may, in practice, hinge on whether one has children or not. There is a presumed correlation between ability to function in the community and the requirements of looking after a dependent child. Although it is assumed that most individuals can bal-

ance the benefits and drawbacks of having children, this assumption, it is argued, cannot be made in the case of some persons and these are more likely to be persons with mental handicaps than other persons.

The justification for intervening in the individual's procreative rights is made on the basis of benefits accruing to the individual. The intervention is limited in two ways — first, it is restricted to those who are mentally handicapped and second, it is only applicable to those persons within that group for whom the dependency of a child will purportedly have a detrimental effect but who are unable themselves to predict that effect. It is deemed to be in the best interest of the mentally handicapped individual to be "saved" from the overwhelming burden both economic and social of children, thus enabling that individual person to function adequately in the community. Such reasoning assumes the capacity of the state to ascertain the ability to raise children and assumes that the state evaluation will be superior to the individual's ability to do so. It also presumes that there are people qualified to make such decisions on behalf of the state.

There is a further benefit which could be argued to accrue if those mentally handicapped persons who are considered to be potentially inadequate parents are sterilized. It is again premised on the notion that the state is more capable than the individual of making the decision. The argument is that if a mentally handicapped person has a child and subsequently proves to be a bad parent, the public will generalize from that particular person's demonstrated bad parenting or from the necessity for the state to bear the cost of rearing that particular child. On the basis of the singular case, community tolerance and public attitudes towards mentally handicapped persons will be undermined. As deinstitutionalization of such persons has been attempted, a variety of problems has arisen partly because of the entrenched suspicion that such persons are unable to function normally. The intolerance already exhibited by some people to handicaps is expressed in a variety of ways, including the view that having children is an indulgence which the public should not have to finance. Thus, it is maintained that members of society will only accept and support

normalization if their irrational fears can be quieted. This, in turn, will require that at least some persons in that class do not procreate.

These arguments can only be held to be valid if accurate determinations of both the actual and potential abilities of mentally handicapped individuals in relation to parenting can be made.

Justifying a denial of the right to procreate to the mentally handicapped on the grounds that the state is thereby protecting them carries with it, however, a denial of the opportunity to exercise the responsibilities that accompany that right. In so doing, the separateness and inferior status of such persons is reinforced. They are required therefore to prove their capacity to do what is a presumed capacity for other persons. In other words, more stringent burden of proof is demanded for these persons than for others. Without some proof (beyond simply mental handicap) that a person is unable to care for children, the justification for state intervention in procreative ability, that is the state's interest in protecting those unable to protect themselves, does not appear to be adequately established.

If we chose to argue the inability to parent thesis, however, there are a number of other factors that should be taken into account. For instance, how can one justify differential treatment of a mentally handicapped person who may not understand the needs of a child and the person who is not retarded but couldn't care less about children. Further it can be convincingly argued that there is an equal degree of irresponsibility of persons who conceive without immunizing themselves against such diseases as rubella which have a clear and identifiable correlation with mental retardation if contracted during the pregnancy. Other factors such as smoking cigarettes during pregnancy are also known to put an unborn child at risk for mental deficiency. Not using birth control under such conditions could then be interpreted as irresponsible in that the future parent is not acting in the best interests of the future child — clearly an indication of inability to parent.

The ability to "nurture" is a pre-condition of child-rearing only in special cases involving adoption or artificial insemination. The problems of decision-making about ability to "nurture" were indicated in the British Columbia Royal Commission on Family and Children's Law.[169]

From this perspective, we would have to argue that the mentally handicapped should be enabled to share in normal social expectations as far as they can and that the state should provide the range of help to make this possible — including, the opportunity to develop one's full potential, to participate in society, and to establish control over one's pattern of life.

The personal rights of the mentally handicapped are often ignored, disregarded or simply violated, not by any express action but simply by default. More emphasis should be placed on ensuring that the mentally handicapped have the same opportunities as all others, and that they are not excluded from general benefits, without good reason.

The issues involved include not only the question of the opportunity to procreate, but also the liberty to procreate. Traditionally the liberty to procreate has not been provided — institutionalization, segregation and lack of sexual education have precluded this liberty. Involuntary sterilization removes the ability to procreate. Deinstitutionalization has, in some cases, provided the opportunity to procreate although lack of sexual education may still be a limiting factor.

3. Further Problems of State Intervention

A decision to implement a policy to limit the procreative rights of mentally handicapped persons necessitates consideration of two additional questions: first, is society unable to bear the burden of caring for a child if the parents prove to be unable; and second, who is going to make the decision that it is to the benefit of a particular individual not to have children.

A. Societal Responsibility

The implementation of a program enabling involuntary sterilization of some mentally handicapped persons suggests that the state does not normally have an ongoing involvement in the rearing of children. It also presumes that the consequence of a mentally handicapped person's inability to parent, that is the effect on the child, is so great that it warrants the establishment of special standards. But the existence of child welfare laws already provides the state with mechanisms to deal with situations where children are receiving inadequate care. One cannot argue that the state is unable to bear such a burden when it has assumed it in cases involving children whose parents are not mentally handicapped. Such a policy would thus again apply more rigid standards to mentally handicapped persons than to the rest of the population.

There is another fallacy in this argument. Neglect and mistreatment of children is not a problem limited to mentally handicapped persons. It is a social problem found in all sectors of the population. This argument therefore does nothing more than confuse the issue of sterilization with the issue of the necessity of social services. If a need exists for day care, expanded social services, and better education, then these resources should be provided in preference to restrictive and penalizing measures against certain classes of people.

B. Decision-making

It must also be determined which members of society are to decide that particular mentally handicapped persons are better off without children. Such decision-making will inevitably be related to the social and political structure in place at the time of the determination.

There is no attempt here to differentiate between judges, scientists, doctors, publicly-elected legislators and so on, but

only to distinguish those who are accorded the power to make decisions and those who are not. Decisions will reflect the values of the decision-makers, as well as their own particular expertise.

There are people who believe that the present division of wealth and power in the society is based on a particular "natural order". They are likely to accept that the existence of inequitable institutions is inevitable and that it can be supported on the basis of unequal distribution of talent, initiative and ambition. Thus, they would argue: those who have power in a society have a right to make decisions and the ability to parent should be measured by the standards of those who hold power. Such persons may consider that the burdens placed on society by certain groups are overall more justified than those placed on society by others.

Such beliefs could lead to a program based on ability to parent that discriminates against the disadvantaged. Such discrimination would not be so much because it was explicitly designed that way but rather because of the presumption that those persons who had achieved less power and wealth, that is, those who it would be assumed, had contributed less, would be believed to be less able. We have already seen evidence of the subjective nature of decisions about sterilization under the Alberta legislation.

Thus, allocation of the decision-making power may in itself determine the kinds of decisions made unless public policy has been clearly outlined and it has been determined whether exceptions to it are morally and socially tolerable.

> The powerful are both ready and able to institutionalize compliance with the moral code at levels congenial to themselves. *Power is* amongst other things this ability to enforce one's moral claims. The powerful can thus conventionalize their moral defaults. As their moral failures become customary and expected, this itself becomes another justification for giving the subordinate group less than it might theoretically claim under the group's common values. It becomes, in short, *normalized repression*.[170]

4. The Presumption of "Qualitative" Differences of Mentally Handicapped Persons

Specific treatment and policy decisions made with respect to persons with mental handicaps will reflect general assumptions about mental handicaps and about deviance in a broad sense.

Those arguing in favour of involuntary sterilization generally do so on the grounds that persons who are mentally handicapped are somehow *qualitatively* different from persons who are not. There are three problems with this presumption of qualitative differences. One involves the assumption that diversity is detrimental to society; the second that it is possible to distinguish this harmful diversity through the application of the concept of handicap; and the third is that the involvement of the state in legislating morality is justified.

Mental handicap becomes translated as a characterization of the whole person rather than just one aspect of that person. The danger in such characterization is that all problems that arise in relation to this class of people are seen as a function of the handicap. Such persons are thereby *a priori* defined as deviants and the implication is that they cannot be entrusted to understand their own situation or to make decisions concerning their own welfare.

The representation of such a qualitative difference is important to the manner in which society treats such persons. At one time or another the role of the deviant individual has been based on their identification as:[171]

- a *subhuman* organism (implying a denial of full human status and therefore not entitled to the full rights and privileges of society; belittling of learning capacities; assumption of extraordinary control, restriction, or supervision; different needs and feelings; devaluation of individuals and thus an assumption that traditional morality need not be applied).

- a *menace* (equating deviance with evilness; persecution based on fear and negative feelings of the unknown; assumptions of propensities to crime or social disorganization and genetic decline).

- an unspeakable *object of dread*.

- an *object of pity* (assuming an imposed condition for which the individual cannot be held responsible and of which he or she may be unaware; individual blameless and thus unaccountable for behaviour; resulting in benevolence, paternalism, lack of respect for individual and view of individual as burden of charity).

- a *holy innocent*.

- a *diseased organism* (equating deviance with "sickness"; a medical model is used for diagnosis and treatment leading to cure).

- an *object of ridicule* (denying the importance of the individual and their right to be taken seriously).

- an *eternal child* (implying that no expectations should be placed on the individual and adapting the environment to the individual).

If mentally handicapped persons are regarded as deviants, then policies developed with respect to them will be formulated on the basis of their incapacity to determine their own behaviour and to fulfilling the role expectations that others, not so defined, are able to fulfil. Such assumptions will likely lead to proposals for sterilization without personal consent. The rationale used as the particular benefit to be derived by the individual will depend on the role that deviants are presumed to play in the society. For example, one might argue that the right to have children accrues only to those who have the capacity to raise them. If the status as persons of the mentally handicapped is questioned, then it would follow that, although biologically capable, such persons are not humanly capable of being parents.

A policy statement issued by the California Department of Health in 1977 regarding *stigmatization and excessive labelling of persons with developmental special needs* recognized the dangers of assumptions about those with mental handicaps.[172] It states that labelling invariably draws negative attention and stigma to the individual or group concerned and supplants the

unique identity and integrity of the person who is stereotyped, doing injury to that person's social value, status, societal mobility and freedom. Furthermore, they maintain, it carries with it the danger of being abused for professional and bureaucratic convenience to the detriment of people with special needs.

Since there is nothing *inherent* in mental handicap that determines whether or not a person is competent to raise children, a presumption about such competence (except in cases of severe mental handicap) may be based upon some general stigmatization and labelling. Further, the definition of neglect is likely to be based primarily on the ability to provide material benefits. And the result will be reflected in a class bias in the probability of sterilization. It is by no means clear that the solution to the problem is a program of state sterilization rather than a restructuring of child care services and the distribution of material goods.

Under the rubric of benefit to society based on qualitative differences, an attempt is made to show that mentally handicapped people are less deserving of social services, for which they are in direct competition with other groups, assuming that state resources are limited. Such an argument involves two presumptions — one, that the contribution of mentally handicapped persons to society is less than others — the underlying basis of comparison being essentially economic and work-oriented. Secondly, that there is a point beyond which a society is not obligated to provide for its members. Although society may have a duty to provide the essentials of life for such persons, they have no right to further burden the community by having children. This is based on the predicted failure of such persons to care for their children and therefore the need for support services to rear them. This presupposes, however, that distribution of social service resources should be made on the basis of economic contribution; rather than on the basis of promoting the fullest development of each individual. If rights to support services are based on economic contribution — rather than need — the mentally handicapped will nearly always be defined as less worthy. On the other hand, if we presume that there is a societal goal to provide the opportunity for each person to develop to his or her fullest

potential, then the mentally handicapped are simply groups with special needs for which the state should provide. The same ethical logic used in other areas of the health field where there are scarce resources, usually presumption of need, should be applied here. Developing methods of self-determination is therefore vital and includes individual choice regarding sterilization.

To realize the ideal of self-determination, information must be made available to enable the individual to make a reasoned choice. In the absence of information, a patient is likely to be reliant on a physician's advice. Linked to the problem of access to information is the fact that traditionally the patient/physician relationship is one of paternalism, authority or dependency.[173] Although this may result in greater efficiency of medical procedures, it is not conducive to self-determination by the patient. The problem is most acute where the patient belongs to a *dependent* class, for example, children, economically dependent persons and potentially persons who are mentally handicapped.

The second problem that arises in advancing the notion of qualitative differences of the mentally handicapped is that it potentially legitimates the legislation of sexual morality for these groups of people. To the extent that a government involves itself in sexual expression, marital relations or reproduction, it is involved to a lesser or greater extent in legislating morality. If it were clearly established that the state should not be involved in private morality, no mandatory laws of any kind bearing on these issues could be legitimately invoked. The basis of the family planning movements has been that the individual has the right to choose the number and spacing of children. By this reasoning a government not only has no right to interfere by law or policy in individual procreative decisions, it should ensure that no other agency interferes and should implement policies that maximize the individual freedom of choice. This goal may involve providing education and information on family planning and where necessary, by actually supplying those services and contraceptive devices which would allow this freedom of choice to be maximized. By not supplying the necessary education, information, and

technology to specific groups and indeed by sterilizing these groups, it is held that qualitative differences not only exist but that they are great enough to warrant "protective" legislation which in effect legislates either directly or indirectly the actual behaviour of such persons. Sexual exploitation of these persons may well be greater than for others but sexual education (both formal and informal) is probably less available as well. If this can be shown to be true then the correlation is between sexual education and sexual exploitation and not between mental handicap and exploitation. In any event, sexual exploitation cannot and should not be solved by resorting to behaviour restrictions or actions directed against the person who is the victim of such exploitation.

5. The Restrictive Nature of Sterilization as a Policy

Even if it is clearly decided that it is possible to determine *fitness to parent* and that there are persons capable and willing to make such weighty decisions, this does not necessarily lead to the conclusion that people ought to be sterilized. Since there are a variety of reversible birth control methods, the onus must be placed on the proponents of sterilization to demonstrate that an irreversible method is required.

Sterilization can be shown to be the most restrictive method of birth control by looking at both the technique and its consequences. (Hysterectomy, presumably would be even more restrictive, although the development of the medical procedures of salpingectomy or tubal ligation have made its use for birth control purposes unlikely since it is a vastly more complicated procedure requiring major surgery.)

Methods of contraception fall into two categories: those requiring no surgical action, and those that do. The two surgical methods are sterilization and abortion. Surgical methods are generally considered more drastic than non-surgical

methods. Non-surgical methods include a variety of means, such as pills, diaphragms, creams and so on which generally are self-administered. In addition, there are some new techniques that require medical administration but not surgery. These include such procedures as intrauterine devices and injections, which are effective over some specified period of time. The risk and effectiveness of any form of birth control must, however, be weighed.[174]

A tool that may be useful in decision-making in this area is the principle of "least restrictive alternative". This is based on the premise that: "When government does have a legitimate communal interest to serve by regulating human conduct it should use methods that curtail individual freedom to no greater extent than is essential for securing that interest."[175]

The application of this principle would require that coercive regulations could be applied only when non-coercive methods could not achieve the same goals. In other words, convincing evidence would have to be shown that direct and inevitable cause and effect links existed between the regulations and the behaviour restricted, and that there are no other means involving fewer restrictions on personal freedom that can achieve the same effect.

In practice, this would mean that it would have to be demonstrated that an individual either could not be taught to use these other forms of birth control, or was not responsible enough to use them even if capable.

To prove that a person *cannot* be taught to use any of the forms of birth control now available may prove difficult, considering the variety of these methods and the fact that social service agencies could probably help in the maintenance of the program. Even if one could prove that a birth control program could not be followed, the availability of "morning-after" pills and early abortion mean that the result will not inevitably be the birth of a child, although the use of such techniques would require the knowledge that the sex act had taken place. In any event, the use of this argument for non-consensual sterilization is not particularly convincing.

Another argument for suggesting that such a restrictive alternative must be used in cases of mental handicap is that some individuals, even if capable of following (*i.e.*, capable of understanding) birth control programs, are *not sufficiently responsible* to do so. In a society that has not yet effectively implemented sex education or birth planning education for its general population and has barely attempted to implement such programs for the mentally handicapped, such an argument cannot be made convincing.

There may be good reason to suggest that some of the available birth control technology may entail high risk factors.[176] For example, there is evidence that oral contraceptives used by minors suppress normal growth and development. Oral contraceptives also have a suspected effect on metabolic functions. The interactive effect of combinations of drugs, an insufficiently studied area, should also be considered where the population may be receiving drugs for behaviour control or physical conditions related to mental retardation. Care must be taken to ensure that mentally handicapped persons like others are made aware of the risks involved in the use of any form of birth control. However, to use the existence of risks as a rationale to deny mentally handicapped persons the availability of such techniques, cannot be legitimated. Unless there is an abnormal risk to an individual, then as long as the drug or device is on the market, mentally handicapped persons must have access on the same basis as all others.

The implementation of any restrictive measures would have to include an articulation, by those involved in making and maintaining the policy and laws, of the state interest being served. Identification of alternative means of accomplishing goals would then be part of the process of developing law. Also, by this means, it could be ensured that the less restrictive alternatives will be found before and not after the most restrictive measures have been taken (suing for loss of procreation ability does little for the sterilized individual even where such a course of action is available).

If laws including legislatively mandated administrative schemes treating mentally handicapped persons as a separate

class (or even as two separate classes — the mentally retarded and the psychiatrically ill) were subject to this principle, then not only would such laws have to be cautiously approached, but each case would still have to be examined to ensure that it did not unnecessarily curtail the particular individual's rights.

The *least restrictive alternative* principle would in most cases require a case by case analysis of policy applied to the mentally handicapped, since so little is known about the effects of the many conditions included. It might also be used to remove present legal barriers to the use of currently available alternatives, and may even be used to compel the creation of new alternative programs or facilities (such as new male contraceptive techniques or safe, long term but impermanent birth control methods).

The practical implications of this principle would likely be a greater use of existing alternatives, an increasing determination of treatment based on individual, rather than on collective needs and the creation of a variety of new alternatives for the mentally handicapped.

In conclusion, if the arguments about sterilization begin with an assumption that there are no qualitative differences between mentally handicapped persons and others, then the problems of conception, child-rearing and so on of the mentally handicapped will be viewed as the same problems faced by all others — their difference being of degree — not kind. It follows that no single group should be singled out and its behaviour sanctioned if similar conduct exhibited by another group would not be subject to the same sanctions. The rules of behaviour should be sufficiently refined to apply to the individual regardless of group affiliation. Thus no special laws should be created for the mentally handicapped. The difficulty of determining exact criteria for competence should lead to immense caution being taken not to focus on a single, narrow, symbolic characteristic that legally entails status.

IV

Issues Raised by Consent

There remains the question whether the state or any other interested third party should intervene in procreative rights even with consent. Because of the vulnerable position of mentally handicapped persons, this will depend to a great extent on the ability and autonomy of the individual to make the decision.

There are three elements to consent.[177] First, it must be voluntary. This assumes an exercise of free will and clearly precludes the existence of coercion or force. Second, it entails a requirement that the individual has the information necessary to make a decision. This includes full disclosure by the physician of the purpose and effects of the treatment, including in the case of sterilization the nature of the operation and the irreversibility of its effects. Third, it is imperative that the person providing the consent have the mental competence to appreciate precisely what is being consented to as well as the implication of the consent.

Consent can be either personal consent (that is, the individual involved provides the necessary authorization) or it may be "third party" consent (that is, the authorization is provided by some party other than the individual involved). The latter is used when an individual is incapable (either lacking capacity or competence) of providing personal consent.

1. Personal Consent

The decision whether a mentally handicapped person is capable of providing personal consent depends on his ability to understand the consequences of his consent. Thus it must be clear that the individual understands not only the nature of sterilization as a surgical procedure but also that sterilization involves a decision not to procreate, and that this decision cannot be reversed once the operation is undertaken. It has already been argued that *no universally applicable standards can be applied to the mentally handicapped since they do not constitute a cohesive, consistent, or definable group*. Thus no standard can be determined as to their ability as a group to understand these facts. Some will be able to understand and give personal consent and some will not.

The issue of voluntariness is also crucially important in dealing with the personal consent of mentally handicapped individuals to sterilization. It is necessary to ensure that those who *can* make a decision, *do* make such a decision when they agree to undergo sterilization. It is quite possible that mentally handicapped persons will be subject to undue influence, coercion, or force by persons who wish to persuade them to undergo sterilization. The stigma attached to such persons leaves them in a vulnerable position particularly if it results in approval from others (see section of paper on deviance model). Persuasion based on such obvious inequality of two parties puts the voluntariness (that is, exercise of free will) of the decision in question.

Such choices cannot be voluntary if they are made in an atmosphere of threatened or implied consequences (either sterilization or institutionalization); when there are misunderstandings about the consequences of the choice (if not sterilization, then children); or deception (because of misunderstanding about the capacity to understand, an explanation is given about a stomach operation with no reference to the actual procedure being performed).[178]

There is nothing *inherent* in mental handicap, however, that prevents a person from providing competent consent to a sterilization. If a mentally handicapped person requests that sterilization be performed, and it is established that he or she understands the nature of the procedure and its consequences and is under no duress to undergo the sterilization, then that person should have the right to exercise or withhold his or her consent. The existence or degree of handicap should not be a relevant issue. In such a case the use of third party consent or the refusal to provide the sterilization denies such persons a right normally accorded to others.

The susceptibility of such persons to undue influence requires, beyond personal consent, some additional safeguards. If there is any doubt as to the voluntariness of the consent, then it *should* be incumbent on the physician to institute procedures to be followed in the case of a person incapable of consent.

2. Third Party Consent

The situation when someone other than the person to be sterilized consents to the procedure poses more problems. In law, third party consent by parent, guardian, or institution is often deemed equivalent to a voluntary consent by the patient. Since there is such a critical difference in law between involuntary and voluntary activity and what may or may not be undertaken, the tests needed to determine the voluntariness are vital. Moral, legal and social problems arise where third party consent is substituted for the personal consent of mentally handicapped persons. As a basis of reform, such consent has been held to be an irony:

> . . . the irony in which involuntary sterilization has been replaced by the fiction of consensual sterilization; and the irony in which consent to surgery will be replaced by consent to 'self-regulating' contraception and abortions.[179]

Sterilization undertaken with third party consent could in extreme cases be construed to be nothing more than involuntary

sterilization without the safeguards that normally attach to involuntary action.

The general rule about parental consent is that it is sufficient to authorize medical care[180] for a minor child because the treatment is presumed to be potentially beneficial to the child. Under normal circumstances, it would seem reasonable to argue that mental handicap is not an issue in applying this rule. In other words, a parent may consent to medical care for a mentally handicapped child if such consent would be sufficient for treatment of a non-mentally handicapped child. However, it is most unlikely that parental consent to non-therapeutic sterilization would be acceptable as an authorization for the procedure in the case of a normal child, because no potential benefit could be argued. Moreover, denying the right to procreate may be viewed as a potential harm. Many persons[181] believe therefore that the performance of sterilization under such circumstances would be illegal. The difficulty with proceeding on the basis of substituted consent, where the patient is not competent, rests in the difficulty of construing a real "benefit" to the patient unless medical necessity can be shown. The fear of parents that they will be responsible for any offspring of a mentally handicapped child may well lead to their consenting to the procedure, the "benefit" of which will be more clearly to the parent than to the patient.

In a recent article[182] in the *Canadian Medical Association Journal* on the legal implications of sterilization procedures carried out on minors or incompetent adults with third party consent, Gilbert Sharpe concludes that such a consent is not "sufficient protection for a physician where the operation is not essential for the treatment of the patient". He maintains that the consent of a parent or guardian alone, even if the person consenting believes it to be in the best interests of the individual in question, should not be considered sufficient to relieve the physician of criminal or civil liability. He is also of the opinion that parental powers do not include the ability to interfere with their child's "natural rights".

The most likely arguments for potential benefit, unless therapeutic, would have to be based on either an inability to

parent or to function effectively in society because of the added burden of a child. However, both these justifications could as easily be directed at non-mentally handicapped minors who had children. Since the developmental potential of mentally handicapped children has not been proven, it can be argued that the benefit of that potential should be extended on the same basis to these children as it is to other children. For these reasons, some legal opinion holds that the only mechanism for the authorization of the practice would be enabling legislation.

Lloyd Perry, the Official Guardian of Ontario, has publicly stated[183] that sterilizations being performed on hundreds of Ontario children are illegal. In his view any sterilization of a person who is incapable of giving legal consent on his own behalf is illegal. "The parent or guardian cannot effectively provide consent themselves if the children are not able to give informed consent themselves". He maintains that sterilizations carried out on mentally retarded children are being performed under the *Ontario Public Hospitals Act* provision that parents have the right to give permission for surgery on children under sixteen — a provision which he says was never intended to deal with sterilization.

There is a further problem with the acceptability of parental consent to sterilization of a mentally handicapped child — one that is not as likely to be applicable in cases of parental consent for normal children. The law generally assumes that parents are sufficiently dedicated to their child's interest to exercise the power of consent for them. We are being made painfully aware that this dedication is not always the case with average children. With the mentally handicapped, it may be less likely to be so and a direct conflict of interest may develop when a mentally handicapped child reaches puberty. Parents may feel that if such a child has an unwanted pregnancy, any offspring will eventually become their responsibility and the decision to consent to the sterilization of the child will be on that basis rather than the benefit to the child. Their personal involvement too readily obscures the proper perspective for their child. The need for birth control is confused with a need for sterilization.

The social stigma emanating from fears within the community based upon the possibility of less control over a retarded adolescent's sexual aggressiveness or vulnerability to sexual exploitation, could be another possible source of such conflict of interests.

The same problems arise with the use of systematic contraception, particularly non-self-administered contraception. Although contraception may be more acceptable because of its non-permanent nature, the social and ethical dilemmas of consent remain. Parents have no greater right to impose these solutions on their mentally handicapped children than on other children. Parental consent may be a necessary but not a sufficient condition in such decision-making.

Because of the nature of the case and its direct relationship to the type of situation we are discussing, a recent English decision[184] involving the sterilization of an eleven year old mentally handicapped female upon the request and consent of her mother, and the advice of her family paediatrician is of interest here. An educational psychologist involved with the girl applied to the court to make her a ward of the court and sought an order continuing the wardship in order to delay or prevent the proposed operation from being carried out. The reasons put forward by the doctor recommending the operation were both medical and social. The medical reasons included the possibility that she might give birth to an abnormal child, that her epilepsy might cause her to harm a child, and that the only satisfactory method of birth control was this operation. The social reasons included his opinion that the girl would be unable in the future to maintain herself in a sheltered environment, her inability due to epilepsy and other handicaps, to cope with a family without substantial support if she were to marry, the deterioration in her behaviour for which he said there was no known method of improvement, and the possibility that she might have to enter an institution for social or criminal reasons in the future.

The judge held that the operation proposed involved the deprivation of a basic human right, *i.e.*, the right of a woman to reproduce, and therefore, if performed on a woman for

non-therapeutic reasons and without her consent, would be a violation of that right. Since the patient could not give an informed consent, but there was a strong likelihood she would understand the implications of the operation when she reached the age of eighteen, the case was held to be one in which the courts should exercise its protective powers, and her wardship was continued.

Secondly, it was held that a decision to carry out a sterilization operation on a minor for non-therapeutic purposes was not solely within a doctor's clinical judgment. In the circumstances the operation was neither medically indicated nor necessary. Nor would it be in the child's best interests since the evidence showed that the child's mental and physical condition and attainments had already improved, that her future prospects were unpredictable, and that she was as yet unable to understand or appreciate the implications of the operation, whereas it was likely that in later years she would be able to make her own choice.

The validity of consent to sterilization by a parent or a court appointed guardian of a mentally handicapped adult may be questionable on a number of grounds. Whether the jurisdiction of a guardian extends to an area such as sterilization is unclear from a legal standpoint. In Alberta specific provision has been made to include health care within the jurisdiction of the guardian. The *Dependent Adults Act* sets out the circumstances in which a guardian may consent to health care on behalf of a dependent adult. For the purposes of the Act health care includes:

(i) any examination, diagnosis, procedure or treatment undertaken to prevent any disease or ailment;

(ii) any procedure undertaken for the purpose of preventing pregnancy;

(iii) any procedure undertaken for the purpose of an examination or diagnosis;

(iv) any medical, surgical, obstetrical or dental treatment and,

(v) anything done that is ancillary to any procedure, treatment, examination or diagnosis.

The court appointed guardian has the power and authority "to consent to any health care that is in the best interests of the dependent adult". It is likely that therapeutic sterilization is included under the definition of health care. It is unclear, however, whether "best interests of the dependent adult" would be interpreted to include non-therapeutic sterilization. In an analysis by the Alberta Social Services and Community Health Department respecting the need for a *Dependent Adults Act*, it was pointed out that any provision for consent to medical treatment "must be in the best interests of the dependent adult as an individual and not the best interests of society. This is not a provision to give effect to consents to experimental surgery or involuntary sterilization."

From a social or moral perspective, consent by a guardian to non-therapeutic sterilization is questionable, notwithstanding the Alberta Act, on similar grounds as those outlined with respect to a mentally handicapped minor. As has been discussed earlier in the paper, the usual rationales for non-consensual sterilization of a mentally handicapped person are not particularly convincing. Nor does third party consent alter the situation. "The outstanding aspect of third party consent is that it usually includes the hazards of involuntary state interventions without the cluster of safeguards that have been developed where state action is pure and simple".[185] Means other than third party consent would therefore seem to be demanded.

Some particularly glaring problems arise when third party consent on behalf of full-time residents in state institutions is permitted. First, state coercion behind such decisions is too easily concealed. Second, persuasion can be brought to bear on parents who already bear the stigma of a mentally handicapped child. Prejudice and guilt are emotions that can too readily be played upon. Finally, administrative convenience may too easily be substituted for the benefit to the individual.

A number of experts have recommended that a committee

system be instituted to review and supply consent to applications for sterilization of the mentally handicapped. Such review procedures are viewed as mechanisms to ensure the voluntariness of the consent to the sterilization. These will be discussed in more detail below. It is interesting to note that in one case, the committee is authorized to consent to the procedure, while in another the committee may not authorize the procedure unless it can determine that the person has formed, without coercion, a genuine desire to be sterilized.[186]

None of the problems raised above, however, should be construed as a denial of the right of the individual to determine himself or herself that he or she wishes to be sterilized. Setting up safeguards to ensure freedom of choice for the mentally handicapped person may result, however, in doctors being hesitant about performing the operation at all. Some experts on mental handicaps have suggested that the whole controversy surrounding sterilization has already led to the situation where some doctors, fearing liability, are refusing to perform the operation, even when there is a legitimate desire by the patient and parents to consent to the operation on the basis of its beneficial nature for the individual. There is a need for enabling legislation as well as for protective measures. These two needs must be balanced if the mentally handicapped are to be assured the same rights as others in the society. In addition, it is important to underline that any legislation or procedures be broad enough to include both institutionalized and non-institutionalized persons.

The history of legislation in this area in Canada and the United States shows that most of the legislation (including most of the present state statutes in the United States)[187] has been designed to enable sterilization through the use of third party consent, rather than by providing guidelines for protecting the autonomy of the individual's personal consent, where this is possible.

V

Proposals Regarding Sterilization Procedures for the Mentally Handicapped

A few states in the United States have established procedures to provide the mentally handicapped with the right to sterilization while protecting them against unnecessary or involuntary procedures. A number of model Acts have also been proposed to deal with the problems in this area. Some of these will be examined here, not necessarily as recommendations of models to be followed, but rather to demonstrate the ways in which the law can be used to approach the issues raised in this paper.

1. Montana Sterilization Law

The purpose of the Montana sterilization law is "to provide a method through proper hearing whereby certain persons whose sterilization would benefit themselves and the state may voluntarily consent to such sterilization under adequate safeguards protecting them against involuntary or unnecessary sterilization".[188] It applies to persons "who would be diagnosed as capable of consent to sterilization but whose capacity to consent has been questioned by a licensed physician".[189]

The initial decision as to the patient's competence is therefore left to the physician. The authorization of the patient

is sufficient where the physician accepts that patient's comprehension and ability to consent.

If the physician questions the patient's ability to consent, the Act provides for a hearing by a state board of eugenics. The board is empowered to conduct hearings to determine whether the individual might be expected to transmit mental deficiencies to offspring or be unable to care for and rear such offspring, and to determine whether the applicant is "capable of understanding and does understand the nature and consequences of the medical treatment he or she will undergo and with such understanding voluntarily consents thereto".[190] The patient and his or her parents or guardian must sign a written consent at the hearing. If the board finds an individual incapable of voluntary consent, however, it is unlawful thereafter for any person to perform or procure a sterilization for that individual.

This statute therefore authorizes the personal and voluntary consent of mentally handicapped persons to their sterilization. It is designed to deal specifically with the problems of non-institutionalized mentally handicapped individuals.

2. Alabama Court Order to Govern the Sterilization of Mentally Handicapped Residents of State Institutions[191]

On December 20, 1973, the three-judge federal court in *Wyatt v. Aderholt* declared that the Alabama eugenics state law was unconstitutional. A companion decision was handed down a month later by a judge in federal district court to promulgate adequate standards and procedural safeguards to ensure that full constitutional protections are accorded to the persons involved for future sterilization.

The provisions in the court order pertain specifically to institutionalized mentally retarded persons. They stipulate that the committee may not approve sterilization unless informed

consent in writing has been obtained from the individual; such consent must be informed in that it is "(a) based upon an understanding of the nature and consequences of sterilization, (b) given by a person competent to make such a decision, and (c) wholly voluntary and free from any coercion, express or implied".

These regulations have a number of other distinctive features. They do not allow the sterilization of any person under the age of twenty-one years unless medical necessity can be determined in accordance with procedural guidelines. A requirement is made that no sterilization may be performed unless no other non-permanent form of birth control will "meet the needs of the person involved". It must be fully documented that the consent obtained from the person involved is fully informed.

Only under three conditions, including specification of the rationale, approval of a board, and a judicial review, may a person deemed to be incompetent (or about whom there is any doubt concerning the understanding of the nature and consequences of the operation) be sterilized. The regulations recognize not only medical and legal factors but also the social, psychological, and ethical issues involved in sterilization. All persons are to be represented by legal counsel paid by the state. The stipulation of the composition of the review committee attempts to counteract the possibility of discrimination against certain groups.

If these regulations err, it is on the side of being overly restrictive, and indeed, they state that in any case of doubt, the matter is to be resolved *against* proceeding with the sterilization.

The drawback to such regulations and review committees is that they further complicate and bureaucratize a decision-making process which should be essentially a personal choice. However, the dangers of abuse in an institution, where the power and influence are so heavily weighted on behalf of the authorities, are so great that there is a need for additional protective measures.

3. United States Department of Health, Education and Welfare Sterilization Regulations[192]

New final regulations, effective February 6, 1979, have been published by HEW, tightening the standards for federal participation in the funding of sterilization procedures. Under the regulations, which were proposed in December of 1977:

- written and oral explanations of the operation and advice about alternate forms of birth control must be provided in a language the patient understands;
- an HEW-approved consent form must be utilized;
- the mandated waiting period between consent and sterilization must be at least 30 days, but not more than 180 days, except in the case of premature delivery or emergency abdominal surgery;
- consent may not be obtained from anyone in labor or childbirth, under the influence of alcohol or drugs, or seeking or obtaining an abortion;
- no federal funds will be available for sterilization of those under 21, mentally incompetent individuals, or for individuals institutionalized in correctional facilities or mental hospitals.

4. Bernard Green and Rena Paul: Proposed Statute on Sterilization of the Retarded Act[193]

Green and Paul in presenting a proposed statute have attempted to remove any doubts concerning the legality of the sterilization of a retarded child. They have based their proposal on two assumptions: "... first, sterilization is non-criminal and should remain so; second, such an operation should be performed on a person who lacks the capacity to provide a valid consent to it only when it is objectively neces-

sary and desirable''. They direct the liability to the physician by making the sterilization of a child, in the absence of required certificates, guilty of medical malpractice and subject to the sanctions of the professional organization and in appropriate circumstances also subject to criminal penalties.

The proposed statute reads as follows:

Sterilization of the Retarded Act

1. A licensed physician may sterilize a person if

   A. he has the consent in writing of that person to the procedure or, if that person is unable to provide a valid consent, the consent of that person's parent or guardian and

   B. he has at least two certificates in a form prescribed by the regulations by mental retardation experts that the person for whom the sterilization is sought is retarded;

      (i) the latest certificate shall be made not more than six months before the operation, and

      (ii) the certificates shall be made at least one year apart.

2. Any person who contravenes any provision of this Act shall be

   A. liable in any action at the suit of the person who has been sterilized illegally or of his parents or of his guardian for damages in the amount of $10,000, unless either party convinces the Court that this amount is unjust in which case the Court shall award such larger or smaller sum as seems just in all the circumstances, and

   B. guilty of a summary conviction offence if he knew the requirements of this Act.

3. Nothing in this Act shall effect the legality of sterilizations performed or sought to be performed for reasons other than the alleged retardation of the person.

Placing the onus on the physician is a logical choice. Sterilization is an elective procedure, in the sense that the physical health of the individual involved will not be affected if it is not performed, but it is also permanent. And in cases of doubt as to whether it is freely chosen, it would seem reasonable that the person performing the operation should be placed under some obligation to ensure that it is appropriate. However, Green and Paul have assumed that the only objective

criterion for third party consent is whether the individual is mentally retarded. As argued throughout this paper, however, mental retardation *per se* cannot be considered a legitimate reason for sterilization. As well, the assumption is made that the parents or guardians, having the best interests of the child in mind, are the persons most capable of determining if the operation is beneficial. Although in many cases this may be true, we have argued that assumptions about parent-child relations that are usually true cannot necessarily be made when the children are mentally handicapped. Therefore additional safeguards must be provided to ensure that such persons are accorded the same rights as other people.

The provisions established to determine mental retardation would, however, provide a safeguard for ensuring that a person is not competent to consent. Taking into account the problems of scientific and medical criteria for mental handicaps, the number of misdiagnoses that have been documented and the possibility of a change in condition, certifying incompetence at two points in time would appear to be a reasonable procedure as a safeguard against these possibilities.

5. The Model Voluntary Sterilization Act: Drafted by the Association for Voluntary Sterilization[194]

A model Sterilization Act drafted by the Association for Voluntary Sterilization recognizes that any legally competent person may consent to voluntary sterilization. In addition, it ensures the availability of contraceptive sterilization for the mentally retarded within procedural guidelines adequate to safeguard the voluntariness, and knowledge of, the consent so obtained. It is intended to uphold the principles enunciated by the 1968 Proclamation of Teheran as adopted by the International Conference on Human Rights which provided that ". . . parents have a basic human right to determine freely and responsibly the number and spacing of their children".

Any mentally retarded person "who has the capacity to understand and appreciate the nature of the medical treatment they are to undergo and the consequences and to manifest assent or dissent thereto" is entitled to the same access to sterilization as a non-mentally handicapped person. If the legal but not factual competence to consent of a mentally retarded person "has been questioned by a licensed physician or might be so questioned", consent to the voluntary sterilization requires an application to and review by the review committee which is provided for in the Act.

The review committee to be established by the Act would be composed of independent members to ensure the disinterestedness of court-authorized sterilization. The committee is to be made up of: one physician (licensed to practice psychiatry), one lawyer, one lay person (on the basis of recommendation of "qualified organizations in the field of mental retardation"); a consulting physician (either a licensed specialist in urology or in gynaecology and obstetrics), and a representative of the particular ethnic, religious or philosophical group of the applicant. Participation in the committee's decision is barred to anyone who has been involved in the care of or is related to the individual involved.

This is similar to the review committee recommended in the guidelines in Alabama. This proposed committee is constituted in such a way as to guard against the more blatant discriminatory potential in this area. For some reason, however, the consulting physician and the representative of the particular ethnic, religious or philosophic group are to be selected by the other three members who are to hold office for three year terms. This may or may not raise problems, but in light of discriminatory practices of previous sterilization boards, it seems appropriate to insist on rigid standards in appointing committees. It would also seem advisable for a paediatrician interested in early child development to be on such a review committee.

Under this model Act, the retarded individual must be guaranteed independent legal counsel to represent his or her interests in the committee decision, to ensure that the indi-

vidual's interests are represented is of extreme importance. However, advocacy programmes[195] have been found to be very successful, and the necessity for the advocate to be legally trained (since there is already a lawyer on the committee) is questionable. The disadvantaged economic position of the mentally handicapped may make this a disadvantage, since parents or guardians may have to pay the costs and therefore influence the proceedings. It is also stipulated that the applicant be present at the review committee's hearings.

At its hearing the review committee's evidence must be presented to establish:

a. Whether the applicant is one of the group covered by Sec. 3.a of this act;

b. Whether the applicant, whether or not a minor, has been counselled as to the nature and consequences of sterilization as defined in Sec. 2.b of this act and whether the applicant understands and appreciates such information and voluntarily assents thereto;

c. If the applicant is under twenty-one (21) years of age, whether his or her parent(s), if living and competent, or, if not, his or her legal guardian understands and consents to the sterilization;

d. If the applicant is over twenty-one (21) years of age, whether any parent(s) or legal guardian who is in custody of the applicant understands and consents to the sterilization;

e. Whether any undue coercion or promise of release from an institution has induced the applicant's consent;

f. Whether sterilization is otherwise ill-advised or whether an applicant is unable or unlikely to procreate;

g. Whether such treatment can be carried out without unreasonable risk to the life and health of the applicant;

h. The method and manner in which sterilization is to be accomplished.

Further, at such hearing the applicant shall designate the person to perform such sterilization who may be any physician and surgeon licensed to practice medicine in the state.

At such hearing, the applicant shall sign a written consent to sterilization in the form to be provided by the committee.

While this stresses the importance of voluntary personal consent, there is also the additional requirement for parental or guardian consent. Making this a necessity seems unnecessary and appears to undermine one of the purposes of the Act.

This model Act accords the individual who is mentally handicapped, and who has the capacity to consent, the right to choose to have children or not. It ensures that a personal informed consent, with its constituent elements of competence, full disclosure, and voluntariness, is the authorization for the procedure. Therefore it prevents the imposition of the wishes of others on the individual.

6. New Zealand Contraception, Sterilization and Abortion Act

On 1 April 1978 the New Zealand Act came into effect.[196] The statute on the authorization of sterilization of "mentally subnormal" persons is directed to the mentally retarded (defined as "suffering from subnormality of intelligence as a result of arrested or incomplete development of mind"). An application for sterilization may be made by the "parent or guardian of the patient, or by any person who is acting in the place of the parent of the patient; the superintendent, manager or licensee of any hospital, home, or other establishment in which the patient is resident; a registered medical practitioner; a social worker concerned professionally with the patient". If the application is made by anyone other than the parent or guardian a copy of the application must be served on them. Every application must be supported by a statement by a medical practitioner that the patient is "mentally subnormal" and a statement by a qualified person giving a professional assessment of the patient's social adjustment and intellectual capacity.

The court is required to examine the patient and to arrange for two medical practitioners to examine him or her to determine that the patient is mentally subnormal. It must also appoint counsel to represent the patient. If ". . . the court is

satisfied that the person is mentally subnormal and that, for his own good, he should be sterilized, the court may make an order in the prescribed form granting the application''.

This piece of legislation does little more than establish procedures whereby an individual can be sterilized upon the fulfilment of substituted consent procedures. There is no attempt to establish criteria for determining competence or to protect the adequacy of consent by handicapped individuals. It clearly makes mental handicap a condition of sterilization, something which has been argued against throughout this paper. It does provide for legal counsel for the individual concerned, but there is no stipulation that the individual involved be served with the application or that he or she be informed as to the nature or consequences of the medical procedure. The Act specifies that the court must be satisfied that sterilization is in the best interests of the individual, but no objective criteria to determine best interests are given.

Such legislation solves none of the social or ethical questions relating to sterilization of the mentally handicapped and denies the right of mentally handicapped persons to procreate. It also denies them a choice of the method of contraception if they decide not to procreate.

7. American Association on Mental Deficiency

The American Association on Mental Deficiency adopted a policy statement on sterilization in 1974.[197] In that statement they propose guidelines opposing the enactment and application of involuntary sterilization statutes. In their consideration of voluntary sterilization, they divide the population of mentally retarded persons into three general categories: (1) competent persons or persons presumed to be competent; (2) legally incompetent persons, and (3) persons of impaired capacity. In the case of persons in the first category, they should ''. . . have the right to exercise free and informed choice, without coercion or constraint, in the selection of contraceptive methods''. In other words such persons should not be distin-

guished from any other citizens. To ensure the maximum possible participation in such decision-making they recommended that the following conditions be met:

(a) He or she should be free from involuntary constraints, such as commitment or legal custody, and possible expressed or implied inducements or contingencies which are controlled by other individual agencies or organizations.

(b) Prior to reaching a decision, each individual should be informed about, and have access to, other less restrictive alternative forms of contraception. When other forms of contraception are tried, they must be offered under circumstances which favour their effective use.

(c) Prior to electing to be sterilized, the person should have a full explanation of the nature and likely consequence of the sterilization procedure and an opportunity to signify his or her understanding. If the person is unable to read, a verified record or transcription of the essential features of the oral interchange should be maintained.

They recommend that a legally incompetent person should never be sterilized involuntarily and should be voluntarily sterilized ". . . only in those exceptional circumstances which have been reviewed and approved by a court of competent jurisdiction". To ensure that a person who is incompetent is not denied access to sterilization while at the same time to assure that the best interest of the individual is paramount in the decision-making process it is recommended that the court review and affirm that *all* of the following conditions are met:

(a) The individual is presumed to be physiologically capable of procreation;

(b) The individual is or is likely to be sexually active in the immediate future;

(c) Pregnancy would not usually be intended by a competent person facing analogous choices;

(d) Less drastic alternative contraceptive methods have proved unworkable or are inapplicable;

(e) The guardian of the person agrees that sterilization is a desirable course of action for his or her ward;

(f) The court has received advice based on a comprehensive medical, psychological, and social evaluation of the individual;

(g) The person is represented by legal counsel with a demonstrated competence in dealing with the medical, legal, social, and ethical issues involved in sterilization;

(h) The person, regardless of his or her level of competence, has been granted a full opportunity to express his or her views regarding sterilization and these views have been taken into account in determining whether to sterilize the individual.

A person of impaired capacity is defined as an individual ". . . who has not been formally declared incompetent, but: (1) on the basis of professional assessment, is found to be sufficiently mentally impaired so as to be unlikely to make a reasoned and informed judgment about an issue as grave as sterilization; or (2) while possessing the mental capacity to make an informed judgment, is under some form of confinement or duress which limits his or her freedom to exercise judgment". For such persons, the report recommends that they should not be sterilized except with the approval of a court of competent jurisdiction. All of the conditions noted for legally incompetent persons should apply ". . . except that the additional approval of the next of kin (or if lacking such kin, of a guardian *ad litum*) should be substituted for the consent of the legal guardian of the person, if there is no legal guardian other than a public official". Thus the intent is to ensure adequate safeguards against unwanted or unnecessary sterilizations particularly in cases where doubt exists as to the capacity to consent or there is any possibility of duress or the person is under some form of custody.

8. Ontario Association for the Mentally Retarded[198]

The Ontario Association for the Mentally Retarded[199] have made the following recommendations relating sterilization and consent to treatment.

The recommendations specific to sterilization[200] were:

It is recommended that non-therapeutic sterilization be defined so as to include all sterilizations performed solely for the purpose of

rendering an individual incapable of reproducing or facilitating the management of feminine hygiene problems, or where there is more than one purpose to the procedure, the second reason is not in and of itself sufficient to justify the performance of the operation. The medical practitioner and ultimately the Court would therefore be responsible for determining that the procedure would not reasonably have been performed but for the purpose of rendering the individual permanently incapable of reproducing or facilitating the management of feminine hygiene problems.

Non-therapeutic sterilization should not be performed on a minor under the age of sixteen.

It is recommended that the substituted consent of a parent or guardian not be sufficient authority for the performance of a non-therapeutic sterilization on a person who lacks the mental capacity to consent on his own behalf.

A court hearing will be required whenever a non-therapeutic sterilization is to be performed on a person who lacks the mental capacity to give a valid consent on his own behalf.

A mentally retarded adult who has the mental capacity to consent must have the same right to accept or refuse the proposed action as does any other person.

It is the responsibility of the physician who performs the sterilization to determine whether the patient has the requisite mental capacity and to determine whether the proposed action is therapeutic or non-therapeutic. If the physician believes that there is some reason to doubt his decision as to the individual's capacity or the nature of the proposed sterilization, he should refer the individual to an "independent advocate". The advocate should meet the patient, ensure that he is informed of his rights and as to the nature of the operation. Where the advocate believes the person lacks the requisite mental capacity or that the sterilization is non-therapeutic, contrary to the physician's determination, the advocate should make application to the Court. No sterilization should be performed on a person, while these issues are pending before the Court.

It is recommended that Ontario adapt legislation dealing with informed consent similar to that of the United States F.R. Doc. 78-31577, September 11, 1978 — Appendix C.

Sterilization is generally a permanent and irreversible operation. It is therefore recommended that:

> At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery, for the consent to be operative. An individual

may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least *72 hours* have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

It is hoped that the delay period will provide sufficient time for an independent advocate to safeguard the patient's rights and will also allow persons to change their minds when they might otherwise have regretted their initial decision.

Where it has been determined, either by the physician or the Court, that the person lacks the requisite mental capacity to consent and the sterilization is non-therapeutic in nature the ultimate decision should be left up to the Court.

The only decision-making body which appears to meet our criteria of (i) independence (ii) informality (iii) procedural safeguards (iv) mandated authority (v) accessibility (vi) speed (vii) reasonable expense and (viii) confidentiality is the Provincial Court (Family Division).

The application should be made on notice to the guardian or next-of-kin, if available.

The ultimate decision should be left to the Court. The Court should be expected to "*stand in the shoes*" of the person concerned, balancing a number of societal values, subject to finding that all the following conditions have been met:

(i) The individual can be presumed to be physiologically capable of procreation.

(ii) The individual is or is likely to be sexually active.

(iii) Pregnancy would not usually be intended by a competent person in a similar situation.

(iv) Appropriate training methods and alternative contraceptive methods have proved unworkable or are inapplicable.

(v) The guardian or next-of-kin (if available) of the person agrees that sterilization is a desirable course of action for his or her ward.

(vi) The Court has received evaluation and recommendations based on a comprehensive medical, psychological and social evaluation of the individual.

(vii) It is unlikely the person will be competent to consent in the foreseeable future.

(viii) The person is represented by an independent advocate,

competent to deal with the medical, legal, social and ethical issues involved in sterilization.

(ix) The person has been granted a full opportunity to express his or her views regarding sterilization and these views have been recorded and taken into account in determining whether to sterilize the individual.

The Court should be required to provide reasons for its decision, and would include the mentally handicapped person's expression of opinion with respect to the sterilization.

These recommendations were proposed in April 1979 in a brief to the Ontario Interministerial Task Force on Sterilization. The O.A.M.R. stated in its brief that it would be defining the term "independent advocate" in a subsequent brief.

9. British Columbia Association for the Mentally Retarded

In June 1978, the Executive Committee of the British Columbia Association for the Mentally Retarded approved two recommendations put forward by their Legal Task Force concerning sterilization, to be recommended to the Superintendent of Child Welfare in British Columbia. These recommendations were:

(1) that the Superintendent of Child Welfare interpret the abuse provisions of the Protection of Children Act to include protection actions on behalf of children for whom sterilization is being contemplated; and,

(2) that consideration be given to amending the Protection of Children Act in order to specifically include sterilization as a form of child abuse.

In making these recommendations, the Task Force pointed out that they should *not* be interpreted to mean that the sterilization or proposed sterilization of a child would constitute abuse in every case. "Rather, it would allow for such abuse actions to be brought in appropriate circumstances. This would give a court the opportunity of determining whether a just and valid cause existed for this severe and irreversible procedure."

10. Canadian Medical Protective Association

The Canadian Medical Protective Association advises its members[201] that if it is determined that "pressing social reasons as well as medical and psychiatric indications for sterilization" are present, such a procedure could be carried out. But the Canadian Medical Protective Association advises that the physician should be made aware that there is no assurance that legal problems will not arise later and further recommends the following safeguards. Both parents, where there are two, should agree to the procedure and if there is any disagreement the operation should be avoided or deferred until an agreement is reached. The procedure should be done only on the urgings of parents and the initiative should not be that of the doctor. The doctor, because of the questionable nature of the validity of the consent, should "be as certain as one can in these situations that no other member of the family is likely to appear later and raise objections to what was done ... There should be near certainty that those who might be objectors have requested the operation or at least concur in its performance". An independent assessment of the child's mental status by a doctor should be made and documented and it should confirm "that the child's mental condition is static, that it is such as to make a sterilization operation advisable and that the mental condition is not likely to improve". The written opinion of this consultant should include a statement that the procedure is "in the patient's best interests". The written parental consent form should include their understanding of the nature and consequences of the procedure and the fact that they have requested it. Finally, the Canadian Medical Protective Association recommends that "wherever possible, some attempt should be made to explain the matter to the individual involved".

11. Donald Zarfas

In a recent study,[202] Donald Zarfas questioned whether the parent's right to give permission for surgery for their children under sixteen years would cover the case of non-

therapeutic sterilization. He recommended an assessment by a multi-disciplinary team of professionals "who are experienced in working with the retarded", and that the mentally retarded person should be represented by someone outside the family to ensure that the decision is made "objectively in the best interests of the person". To make such a determination he recommended that this team should look at the following questions:

- Is there active or highly probable heterosexual activity?
- Is there apparent evidence of the ability to conceive, *e.g.* Down's Syndrome has a low probability?
- Is the person likely to transmit a genetically-determined abnormality?
- Is the person aware of the responsibilities and able to meet the needs of a developing child and, therefore, could be considered to be a relatively good parenting-risk?

In addition, he suggested that attention should be directed to ensuring that the medical procedure undertaken is the least restrictive alternative.

With respect to consent, he maintained that the consequences of surgery for sterilization are likely to be recognizable for those persons with an I.Q. higher than 50. Even in cases where the I.Q. is below 50, his contention was that in select cases with sufficient explanation, informed consent could be considered. An advocate, outside the family or staff associated with day-to-day care of the person, should sign the consent, along with the patient, indicating that it is "in their opinion in the best interests of the retarded person".

Thus to protect all the persons involved he stated:

- The patient needs to be protected from well-meaning but poorly-informed parents or other caretakers.
- The surgeon needs protection from future legal action even when he believes that he is acting in the best interests of the patient, subsequent to informed assessment and consent.
- The advocate needs official status not now provided by law.

12. Canadian Medical Association

The Canadian Medical Association in 1970 passed the following resolution on sterilization:

> THAT any procedure for the purpose of producing sterilization of either male or female is acceptable in the following circumstances:
>
> (a) when it is performed by a duly qualified medical practitioner; and
>
> (b) if performed in an active treatment public hospital, or other locations with adequate facilities; and
>
> (c) if performed with the written permission of the patient, and after the patient has signed a statement to the effect that he or she understands that the sterility will in all likelihood be permanent; similar consent of the spouse, or guardian if applicable, should be obtained whenever possible.

13. British Columbia Medical Association[203]

The British Columbia Medical Association passed a resolution stating that where a patient is mentally handicapped, the patient's advocate should be involved in decisions about sterilization. They did not specify who should be the advocate but the underlying idea was that it should be someone *other than* the parent or guardian or an institution.

14. Ontario Medical Association Guidelines for Sterilization of Mentally Retarded Persons

In April 1979 the Ontario Medical Association wrote a set of guidelines for sterilization of mentally retarded persons. In those guidelines they include the following as indications for elective sterilization:

(a) that there is clear benefit to the patient;

(b) risk of pregnancy. There is clear evidence of existing risk of pregnancy including

(1) evidence of heterosexual experimentation

(2) apparent evidence of ability to impregnate or conceive and the procedures of oral or parenteral contraceptive medication and I.U.D. have been considered unsatisfactory

(c) control of menstruation. Where hysterectomy is contemplated for control of menstruation in a severely retarded person, measures to train the child in management of menstrual discharge have been unsuccessful and oral or parenteral contraceptive steroids are considered inappropriate.

They suggest that candidates for sterilization be examined by three doctors: a paediatrician or internist depending on age; a gynaecologist, urologist or general surgeon, and a psychiatrist. Further they suggest a hospital sterilization committee be established, from among the medical staff, with *possible* lay persons included in it to carry out the following "duties".

(1) to consider the written request for sterilization

(2) to decide whether the pre-sterilization assessment and documentation is complete

(3) to decide whether the proposed procedure is in the best interest of the patient

(4) to decide whether the procedure may, or may not be performed on that patient in that hospital.

The consent for the procedure must be forthcoming from the parent or guardian for the committee to authorize such a procedure.

The objectives[204] of the guidelines clearly state what they are intended to achieve: that is, essentially the clarification of the legal position of the doctor in cases of sterilization. However, they do not include adequate criteria to assist the committee in determining "best interest", which as this paper has argued is one of the basic issues in this question. In addition, they do not adequately recognize the fact that the decision in cases of non-therapeutic sterilization is not only a medical decision but also a social decision and therefore may require expertise outside the medical profession. In addition, the

establishment of hospital committees may be problematic because it can lead to differential access to and inconsistent determinations regarding the procedure dependent upon the particular hospital to which a patient goes. This reduces the probability of equal treatment for all persons.

VI

Recommendations

Throughout this paper the difference between policy and practice in the area of sterilization of the mentally handicapped has been demonstrated. We have shown that where legislation on the subject has been enacted, its stated goals have not been accomplished. The law tends to be a very blunt instrument which, by its very nature, cannot accommodate the individual differences of every case. This problem is compounded when the law is involved in an area like medicine where it must take into account the complex nature of the individual person, that is, the individual's moral, social, and psychological make-up. In this area, it is important that the law, while setting broad guidelines, should not infringe on either the patient's or the doctor's ability to determine the best treatment and care.

However, the general practice of sterilization has led to discrimination against certain classes of people. The state would be remiss to leave the decision-making in an area as sensitive as this completely to the medical profession, who need in any case to be able fully to determine their legal rights and responsibilities in regard to such decisions. On this basis, public policy needs to be developed in the form of legal guidelines, to ensure that medical decision-making in the final analysis is the joint task of the individual patient and the doctor.

The Commission recognizes that a wise and successful solution to this problem will require the joint efforts of federal

and provincial governments. Only with the combined resources and jurisdictional powers of both levels of government can the prevention of potential abuses and maximum benefits for persons with mental handicaps be provided.

On the basis of the stormy history of treatment of mentally handicapped persons regarding sterilization, a number of problems can be identified. It is with these problems that the law should properly be concerned. It can set the substantive guidelines and procedural safeguards under which sterilization can be performed, but not unjustly applied.

These guidelines should be based on the following underlying principles:

(a) persons should not be assumed to be incapable of consent due to mental handicap, even if institutionalized or subject to a court order or interdiction;

(b) mentally handicapped persons, especially those who are institutionalized and minors, should not be presumed to have the same ability to decide as other persons;

(c) it should be the responsibility of the physicians involved in the sterilization procedure to ensure that the individual to be sterilized has understood the procedure and fully consented without undue influence.

The basis for the procedures for sterilization, should be the following classification:[205]

(a) *Voluntary therapeutic sterilization*: this would be any procedure carried out for the purpose of ameliorating, remedying, or lessening the effect of disease, illness, disability, or disorder of the genito-urinary system, and with the fully-informed consent of the patient.

(b) *Emergency therapeutic sterilization*: this would be the same procedure as in (a) (above) carried out in a

medical emergency and where the patient or next-of-kin is unable to give consent.

(c) *Voluntary non-therapeutic sterilization*: this would be a safe and effective procedure resulting in sterilization when there is no disease, illness, disability, or disorder requiring treatment but the surgery is performed, with the fully-informed consent of the patient, for:

(i) the control of menstruation for hygienic purposes;

(ii) the prevention of pregnancy in a female; and,

(iii) prevention of ability to impregnate by a male.

(d) *Involuntary non-therapeutic sterilization*: this classification would be for the same procedures as in (c) (above) but where the person is not competent to give consent.

Therapeutic sterilization should be treated according to the broader general provisions respecting medical treatment proposed in the forthcoming Law Reform Commission's Working Paper on treatment in the criminal law.[206] An individual who is mentally handicapped should be treated in the same manner as other persons with respect to medical treatment. On this basis, a mentally handicapped person who understands the nature and consequences of the procedure and is under no duress, should have the option to consent to or refuse sterilization. A request by a parent, guardian, or any other person on behalf of an individual should never by itself operate as a valid substitute for the consent which the individual does not or cannot give.

For non-therapeutic sterilization, the following problem areas have been identified as those in which objective, determinable standards need to be met for mentally handicapped persons:

- the procedures for determining the competence of a person to give a valid consent regarding sterilization;

- the circumstances in which proceedings for sterilization, either by the state or by an individual, should be initiated;

- the safeguards and procedures necessary to ensure the rights of mentally handicapped persons to give or withhold consent, if able to do so, or to be fairly represented if unable to give consent;

- the mechanisms whereby a determination can be made about who should provide the consent and to ensure that the consent is given voluntarily.

It is thus apparent that two distinct mechanisms need to be implemented to meet these problems and ensure objective standards. One is a process for determining competence to give a valid consent. The other is a process to enable decisions about sterilization to be made, when the patient is found to be incapable of giving or withholding a valid consent.

1. The Finding of Incompetence

The initiation of hearings for determining the validity of a consent to sterilization should be instituted if any one of the following circumstances prevail:

(a) the presumption of an individual's capacity to consent is questioned;

(b) the request for sterilization has emanated or can be presumed to have emanated from a third party;

(c) there is any indication that the individual requesting his or her own sterilization is specially susceptible to

coercion or undue influence to consent to such treatment.

The physician should initiate proceedings, if (s)he knows that any of those conditions exist showing that there are doubts as to the validity of the consent. This should not, however, preclude any other person who has reasonable belief that such conditions prevail from initiating such a proceeding.

A judicial hearing should be held to ascertain whether the individual has the capacity to consent. Such hearings should ideally be held in a unified Family Court as outlined in the Law Reform Commission's Report to Parliament, *Family Law*;[207] however, in the absence of such a court, the Commission is of the view that they should be held before a superior, county or district court.

In the judicial hearing, the determination of the capacity of the individual to give consent should be based on that individual's ability to understand[208] the nature and consequences of the particular medical procedure of sterilization. The determination of capacity should *not* be predetermined by the form or degree of mental handicap. It should relate to the validity of a specific choice made on the record by a person either assenting to or refusing sterilization. If that person expresses no specific choice, then that fact should be entered on the record as a refusal. The standard of competence would therefore involve an ability to understand that sterilization removes the capacity to procreate and that the removal of this ability is irreversible and that reversible methods of contraception are available to that individual. Such a hearing should always involve the *viva voce* testimony of expert witnesses, and not rely on affidavit evidence.

The mentally handicapped individual should be represented at such hearings by a person who the court is satisfied will provide independent advocacy on behalf of the individual. To assure that the advocate has no conflict of interest in the decision, the individual acting in that capacity should not be involved in the day-to-day care of the individual or be either the guardian or a relative of that person. This enables

relatives or guardians to express their knowledge and opinions as witnesses to the hearing, and if desired, to retain their own counsel.

Finally an appeal to a superior appellate court should be available, even if the mentally handicapped person apparently cannot instruct counsel. In such instances provincial rules of procedure ought to express appropriate standards and avenues of initiating an appeal in proper circumstances.

If the court rules that an individual's decision is valid, then the particular choice of the patient could be relied upon by the physician as discharging his or her responsibilities of ensuring proper consent according to usual practice.[209]

If a ruling is made that an individual is incompetent, then an advocate should be appointed by the court to act on behalf of the individual for a sterilization authorization board hearing.

To ensure that the findings of the court are readily available to medical personnel who may need to verify whether such a hearing has been held, as well as to enable statistical evaluation, all findings, judgments and orders of the court in competence hearings pertaining to sterilization should have to be filed with the sterilization authorization board. Procedures should be established for the use of this body of information.

2. Decisions on Sterilization

Where there is no valid consent and in the case of any person younger than sixteen years,[210] no non-therapeutic sterilizations should be permitted, except with legal authorization provided by a board established for that purpose.

Instituting such a procedure for children may be considered contrary to recent trends towards greater autonomy in decision-making. However, the Commission has determined that an exception to this trend needs to be made in this

circumstance. The developmental potential, the contravention of a basic human right, and the possibility, whether intended or not, that parental or institutional interests rather than the interests of the child will be served, lead to the conclusion that in all cases, non-therapeutic sterilization of a child should be carried out only after a sterilization authorization board hearing has been held. This view is consistent with recommendations which have been put forward in Alberta and Saskatchewan with respect to consent of minors to health care legislation. The Alberta Institute of Law Research and Reform[211] recommended that: "Nothing in the proposed *Act* permits a minor to consent to surgical sterilization." They further specifically excluded surgical sterilization as a form of treatment. The tentative proposals of the Law Reform Commission of Saskatchewan[212] include therapeutic sterilization but exclude non-therapeutic sterilization in the proposed Act. That Act includes in the definition of health care:

> the sterilization of a person before the age of majority where it is the treatment for some present or inevitable disease but excludes the sterilization of a person before the age of majority where the sole purpose of the operation is to prevent the possibility of reproduction.

The Act does not indicate whether sterilization for the purpose of prevention of pregnancy is prohibited or simply falls outside the scope of health care.

The Uniform Law Conference's[213] *Medical Consent of Minor's Act* includes ". . . any procedure undertaken for the purpose of preventing pregnancy . . ." in the definition of medical treatment. No distinction is made between therapeutic and non-therapeutic sterilization. The proposed Act requires that the consent of minors (under 16) be supported by the written opinion of a second legally qualified medical practitioner that:

(a) the minor is capable of understanding the nature and consequences of the medical treatment, and

(b) the medical treatment and the procedure to be used are in the best interests of the minor and his continuing health and well-being.

No authorization should be made by the board in respect of any minor person who is not independently represented by an advocate judicially appointed or acceptable to the board. However, because of the nature of the decision, and the possibility of a conflict of interest, it would be inappropriate to extend the role of a court-appointed guardian to include representing the interests of the person in such a case. Such a guardian might well be a distinguishable party in the proceedings, to be represented by his or her own counsel.

Since the purpose of the authorization board is to determine the benefit to the individual of undergoing or not undergoing a sterilization, it should not be designed as a fully adversarial proceeding. The procedure should be designed to maximize informality without compromising fairness. The proposal for a board rather than a court decision is primarily to ensure that those persons most qualified to determine "real" benefit be given the most appropriate opportunity and forum to determine the most beneficial action.

The sterilization authorization board should be composed of a multidisciplinary team of people qualified to evaluate the medical, social and psychological benefits for the patient and to determine if there is a compelling interest to justify the operation. Appointments to the board should be made by the provincial minister or ministers responsible for the mentally handicapped from a list prepared by the government authority responsible for persons who are minors or incompetents in the applicable province. An advisory panel could assist in the development of such lists.

Included on the board should be someone capable of assessing relevant medical and psychological evidence such as a psychologist, a medical specialist in urology, or gynaecology and obstetrics, a paediatrician with an interest in early child development, or a family practitioner with expertise in mental handicap. Since the board must deal with an issue to be resolved on more than technical grounds, there should also be included on the board persons involved in advocacy actions or programs, persons who would be capable of assessing social and ethical evidence; lay persons (with some expertise in the

area of mental handicap or human rights). At least one member of the board should be a legal officer with the sole jurisdiction to determine questions of law arising in any proceeding.

The sterilization authorization board should be required to ensure that the following minimum criteria be established before authorizing a sterilization procedure:

(a) the individual is probably fertile, and there is some evidence to that effect;

(b) the individual is both of child-bearing age and sexually active and other forms of contraception have proved unworkable under the particular circumstances of each case or are inapplicable so that pregnancy is a likely consequence;

(c) there is more compelling evidence than age or mental handicap alone that childbirth itself or childrearing itself will probably have a psychologically damaging effect on the individual;

(d) the sterilization will not in itself cause physical or psychological damage which will be greater than the beneficial effects to the individual, based on a comprehensive medical, psychological and social evaluation;

(e) the views of the individual have been taken into account in the determination regarding whether or not to sterilize; and

The sterilization authorization board should be required to maintain a transcript of the proceedings and submit written reasons for its decision, including the basis of its conclusions of fact and consideration of other alternatives. Provision for an appeal on both facts and law should be established.

Since values inevitably play a part in such decisions, it is possible that, even with the recommended procedures and

safeguards, an imbalance of females, ethnic groups, etc. may be found to receive sterilization authorizations from the board. Since, from experience it can be shown that no structure, no matter how well designed, can by its very nature always guarantee absolute fairness and equal treatment, it is vital that evaluation mechanisms be implemented as part of the procedure. Carefully detailed statistics must therefore be generated, and an external, independent evaluation of the boards should be carried out every two years. Consideration should be given to placing the evaluation procedures within the jurisdictions of Human Rights Commissions. Those Commissions may also have a role in public education and attitude change in respect of mentally handicapped persons. In the final analysis, these may be the only measures through which fairness, justice, and equality may be ensured for such persons.

VII

Summary of Recommendations

In summary, the Commission recommends:

(1) That the legal basis for procedures for sterilization be based on the following classifications:

(a) *Voluntary therapeutic sterilization*: this would be any procedure carried out for the purpose of ameliorating, remedying, or lessening the effect of disease, illness, disability, or disorder of the genito-urinary system, and with the fully-informed consent of the patient.

(b) *Emergency therapeutic sterilization*: this would be the same procedure as in (a) (above) carried out in a medical emergency and where the patient or next-of-kin is unable to give consent.

(c) *Voluntary non-therapeutic sterilization*: this would be a safe and effective procedure resulting in sterilization when there is no disease, illness, disability, or disorder requiring treatment but the surgery is performed, with the fully-informed consent of the patient, for:

(i) the control of menstruation for hygienic purposes;

(ii) the prevention of pregnancy in a female; and

(iii) prevention of ability to impregnate by a male.

(d) *Involuntary non-therapeutic sterilization*: this classification would be for the same procedures as in (c) (above) but where the person is not competent to give consent.

(2) That therapeutic sterilizations fall within the broader provisions respecting medical treatment proposed in the Law Reform Commission's forthcoming Working Paper on treatment in the criminal law.

(3) That, for the purpose of criminal law, mentally handicapped persons who understand the nature and consequences of the sterilization procedure and are under no coercion or duress should have the same options to consent to, or to refuse, sterilization as other persons.

(4) That, for the purpose of criminal law, a judicial hearing be held to determine competence to consent to sterilization according to the following criteria and procedures:

(a) a hearing be initiated to ascertain whether an individual has the capacity to consent if any one of the following circumstances prevail:

(i) the presumption of an individual's capacity to consent is questioned;

(ii) the request for sterilization has emanated or can be presumed to have emanated from a third party;

(iii) there is any indication that the individual requesting his or her own sterilization is specially susceptible to coercion or undue influence to consent to such treatment.

(b) the hearing be held in the Unified Family Court; however, in the absence of such a court, it be held in a superior, county or district court;

(c) the finding of the capacity of the individual to consent be dependent on the individual's ability to understand the nature and consequences of the medical procedure of sterilization;

(d) the individual be represented at such hearings by a person who, the court is satisfied, will provide independent advocacy on behalf of the individual;

(e) a right of appeal to a superior appellate court be provided by law;

(f) if the court rules that an individual's decision to be sterilized or not to be sterilized is valid, the particular choice of the patient may be relied upon by the physician as discharging his or her responsibility to obtain and record the proper consent of the patient according to usual practice;

(g) if the court rules that an individual is incompetent, an advocate be appointed by the court to act on behalf of the individual for any sterilization authorization board hearing;

(h) all findings, judgments, and orders of the court in competence hearings pertaining to sterilization be filed with the sterilization authorization board.

(5) That in any case where there is no valid consent and in the case of any person younger than sixteen years, no non-therapeutic sterilization be permitted except with legal authorization provided by a board established for that purpose and operating according to the following criteria and procedures:

(a) any person appearing before the board be represented by an independent advocate judicially appointed or acceptable to the board;

(b) the board be composed of a multidisciplinary team of persons qualified to evaluate the medical, social, and psychological benefits of sterilization to the individual and to determine if there is a compelling interest to justify the operation;

(c) appointments to the board be made by the provincial minister or ministers responsible for the mentally handicapped from a list prepared by the government authority responsible for persons who are minors or incompetents in the applicable province;

(d) appointments to the board include:

(i) persons capable of assessing relevant medical and psychological evidence;

(ii) persons such as advocates capable of assessing social and ethical evidence, and lay persons with expertise in mental handicap or human rights;

(iii) a lawyer with the jurisdiction to determine questions of law arising in any proceeding.

(e) the board be required to ensure that the following minimum criteria are established before authorizing a sterilization procedure:

(i) the individual is probably fertile, and there is some evidence to that effect;

(ii) the individual is both of child-bearing age and sexually active and other forms of contraception have proved unworkable

under the particular circumstances of each case or are inapplicable so that pregnancy is a likely consequence;

(iii) there is more compelling evidence than age or mental handicap alone that childbirth itself or childrearing itself will probably have a psychologically damaging effect on the individual;

(iv) the sterilization will not in itself cause physical or psychological damage which will be greater than the beneficial effects to the individual, based on a comprehensive medical, psychological and social evaluation;

(v) the views of the individual have been taken into account in the determination regarding whether or not to sterilize; and

(f) the board be required to maintain a transcript of the proceedings and submit reasons for its decision including the basis of its conclusions of fact and consideration of other alternatives,

(g) a right of appeal from the decision of the board be provided by law on matters of both fact and law,

(h) an independent, external evaluation of the sterilization authorization boards be carried out every two years and the evaluation procedures be placed within the jurisdiction of human rights commissions.

VIII

Conclusion

In the context of our general knowledge about the groups of people (women, children, mentally handicapped) to whom protective laws apply and the subjective nature of such categorization in the case of mental handicap, it is critical that great care be taken to specify clearly the basis and need for protection.

The stigma imposed on such persons by their characterization as "persons in need of protection" is emphasized by the implication that such persons lack some quality of humanity that precludes them from the general rules of treatment usually accorded other members of society. This has important implications in law and particularly in criminal law. As a group they are warranted protection which affects their ability to determine their sexual and reproductive behaviour. As deviants, we punish them for their incapacities by restricting their sexual and reproductive behaviour. Societal attitudes regarding the sexuality of such people are clearly spelled out in the law and, subsequently, differentiation among such persons is often not made. If judicial protection is necessary it should permit the same kind of sexual expression accorded others, rather than preventing such expression. In the zeal of the law to protect, what has occurred is protection "against" rather than protection "for" such categories of persons. The laws have been founded on unsound, unscientific views that have resulted in treatment based on group rather than individual characteristics. As a result the laws have the potential for discriminatory results in practice.

Unless safeguards to avoid differential application of the law (which must include on-going evaluation of the application of medical procedures and law) are built in, the victimization of mentally handicapped persons may continue. The state through criminal law as well as civil proceedings should try to strike a fine balance in this regard. It must both protect such persons and still give adequate scope for individual choice to be expressed and to prevail. Persons who are mentally handicapped simply constitute a group with special needs. Self-respect, dignity, and self-determination must be guaranteed for each individual, including those with limitations. The law should not only uphold but also enhance these essential human qualities.

Endnotes

1. Robitscher, Jonas, (ed.), *Eugenic Sterilization*. Springfield, Illinois: Charles C. Thomas, 1973, p. 3.

2. There are a number of techniques of sterilization that are used. The types of operation usually used for female sterilization include hysterectomy, tubal ligation or salpingectomy (including the Irving procedure, the Pomeroy technique, the Madlener operation — the latter being rarely used now because of its unreliability), or laparoscopic sterilization. The first two require general anaesthesia and the opening of the abdominal cavity and are generally designated as major surgery. Laparoscopic sterilization does not involve major surgical incisions and can be performed under local anaesthesia but is usually carried out under general anaesthesia. It does not necessarily require hospitalization. All of these operations involve some risk to the patient.

   Male sterilization, vasectomy, is a simpler procedure which takes about twenty minutes and may be performed in the physician's office under local anaesthesia. The vas deferens, the tube connecting the testes with the urinary canal, is severed and tied, preventing the sperm from passing into the urinary canal. There may be some slight discomfort or a possibility of slight infection following the operation, but usually the patient is not inconvenienced for more than a few days. (Pritchard, Jack A. and Paul C. Macdonald, *Williams Obstetrics* (Fifteenth Edition), New York: Appleton-Century-Crofts, 1976; Danforth, David N. (ed.), *Obstetrics and Gynecology* (Third Edition). Maryland: Harper and Row Publishers, 1977; Jeffcoate, Sir Norman, *Principles of Gynaecology* (Fourth Edition). London: Butterworth & Company Publishers, 1975.).

3. The Roman Catholic Church's doctrinal position has been opposed to measures designed to interfere with the process of human procreation. Pope Paul VI's encyclical Humanae Vitae of the 29th of July 1968. Boyle, John P., *The Sterilization Controversy: A New Crisis for the Catholic Hospital*? New York: Paulist Press, 1976.

4. Recently, there has been a renewed public demand to extend the practice of non-consensual sterilization to new areas — to include not only mentally handicapped persons but also the recipient of welfare or the unfit parent. (See for instance, the *Globe & Mail*, 24 April 1978, p. 1). See also Proceedings of the Senate Subcommittee on Childhood Experiences as Causes of Criminal Behaviour. Issue No. 9, February 16, 1978. Witness: Mary Van Stolk, President, The Tree Foundation of Canada Ltd.

5. Other such procedures might include sexual reassignment surgery, or cosmetic surgery.

6. The probability of reversal is unlikely in most cases of sterilization. The permanence of sterilization is qualified, however, by the possibility either of recanalization or a surgical reversal of the operation. The reconstruction operation is much more difficult than the original sterilizing procedure. Pregnancy rates following reanastomosis of either vas or oviduct average at most thirty percent and depend on the amount of tissue damage associated with the original procedure. (Pritchard and Macdonald, 1976, *op. cit.*; Danforth, 1977, *op. cit.*; Jeffcoate, 1975, *op. cit.*)

7. See Section III, 1. of this paper.

8. The distinction between these two classifications has been drawn in the following manner: "A mentally retarded person is one who functions in a manner corresponding to his mental age, whereas a mentally ill person is one who has a normal mental potential but functions in an abnormal manner due to an abnormal function of those normal mental facilities." Carter, Charles H., *Handbook of Mental Retardation Syndromes* (Third Edition). Springfield, Illinois: Charles C. Thomas, 1975.

9. R.S.A. 1955, c. 311, and R.S.B.C. 1960, c. 353, ss. 5(1).

10. Dybwad, Gunnar, "Legislative Needs in the Field of Mental Retardation". A position paper prepared for the Seminar for the Study of Legislation and Applied Norms in the Field of Mental Retardation, convened August 7-9, 1974 in Sao Paulo, Brazil by the Project MINIPLAN APAE 1/73, p. 3.

11. Gelof, M., "Comparison of Systems of Classification Relating Degree of Retardation to Measured Intelligence", *Eugenics Quarterly*, June 1964.

12. Gelof (*ibid.*) identified five general subgroups of classification:

    (1) interdisciplinary in purpose (broad enough to be used by different disciplines for identifying and grading mental retardation);

    (2) sociological in nature (generally concerned with diagnosis and prognosis for handling the intellectually handicapped in his/her cultural environment);

    (3) legal classifications (reflective of legal thinking over time);

    (4) psychological classifications;

    (5) educational classifications (reflects concern of educators both with educational and socioeconomic prognosis).

    Within each of the identified subgroups there were also wide variations of classification.

13. *Ibid.*, p. 315.

14. Heber, R., "A Manual on Terminology and Classification in Mental Retardation" (Second Edition), *American Journal of Mental Deficiency*, Monograph Supplement, 1961b.

15. Townsend, Peter, "Social Planning for the Mentally Handicapped" in *Sociology and Social Policy*. London: Allen Lane, Penguin Books Ltd., 1975.

16. The President's Committee on Mental Retardation, *Mental Retardation: The Known and the Unknown*. Washington, D.C.: Department of Health, Education and Welfare, February 1, 1975.

17. Townsend, Peter 1975, *op. cit.*

18. Gartner, Alan, Colin Greer and Frank Riessman (eds.), *The New Assault on Equality: IQ and Social Stratification*. New York: Perennial Library (Division of Harper and Row) 1974.

19. Mercer, Jane R., *Labeling the Mentally Retarded*. Berkeley, California: University of California Press, 1973.

20. The President's Committee on Mental Retardation in the United States estimates that there are 250 known causes. The President's Committee on Mental Retardation, *Mental Retardation: Century of Decision*. Washington, D.C.: Department of Health, Education and Welfare, March 1976.

21. Milunsky in his aetiological classification of mental retardation broke it down into two major categories of genetic and acquired factors:

GENETIC

Type	*Example*
Chromosomal abnormalities	Down's syndrome, trisomy 18, trisomy 13
Disorders of amino acid metabolism	Phenylketonuria, maple-syrup urine disease
Disorders of mucopolysaccharide metabolism	Hunter's or Hurler's syndrome
Disorders of lipid metabolism	Tay-Sachs disease
Disorders of carbohydrate metabolism	Fucosidosis, galactosemia
Disorders of purine metabolism	Lesch-Nyhan syndrome
Miscellaneous inborn errors of metabolism	I-cell Disease
Consanguinity, incest, etc.	Schilder's disease, retinal degeneration, etc.
Hereditary degenerative disorders	Congenial hypothyroidim, pseudohypoparathyroidism
Hormonal deficiency	Primary microephaly, X-linked hydrocephalus

GENETIC *(cont.)*

Type	*Example*
Hereditary syndromes or malformations	Tuberous sclerosis
Neuroectodermatoses	Tuberous sclerosis
Unknown	

ACQUIRED

Prenatal	
Infection	Rubella, toxoplasmosis, cytomegalic inclusion disease
Irradiation	Microcephaly
Toxins	Ethyl alcohol, mercury
Unknown	Malformations, placental insufficiency
Perinatal	
Prematurity	
Anoxia	Birth injuries, hypoglycemia
Cerebral damage	Hemorrhage, trauma, infection
Infection	Meningitis, encephalitis
Postnatal	
Brain injuries	Accidents, hemorrhage from coagulation defects or other cerebrovascular accidents, thrombosis, ruptured aneurism
Infection	Meningitis, encephalitis, brain abscess
Anoxia	Cardiac arrest, hypoglycemia, respiratory distress syndrome
Poisons	Lead, mercury, carbon monoxide
Hormonal deficiency	Hypothyroidism
Metabolic	Hypernatremia, hypoglycemia
Postimmunization encephalopathy	Rabies, pertussis, smallpox
Sociocultural	Deprivation
Kernicterus	
Epilepsy	

Milunsky, Aubrey, "The Causes and Prevalence of Mental Retardation" in *The Prevention of Genetic Disease and Mental Retardation*. Toronto: W. B. Saunders Co., 1975, p. 20.

The American Association on Mental Deficiency medical classification system provides for eight broad categories which are defined essentially to be aetiologic or pathogenetic factors — infection, intoxication, trauma, metabolic disorder, undetermined prenatal influences of a physical nature, encephalopathy of undetermined origin, and familial or psychogenic determinants. See Benton, Arthur L., "Psychological

Evaluation and Differential Diagnosis" in *Mental Retardation*. H. A. Stevens and Rick Heber (eds.). Chicago: University of Chicago Press, 1964.

For a detailed discussion of the aetiology of mental retardation, see Clarke, A. D. B., and Ann M. Clarke, *Recent Advances in the Study of Subnormality* (Second Edition). London: National Association for Mental Health, 1975.

22. See Milunsky, A., 1975, *op. cit.*; Berg, J. M., "Aetiological Aspects of Mental Subnormality: Pathological Factors" in *Mental Deficiency: The Changing Outlook* (Third Edition) Clarke and Clarke (eds.). London: Methuen, 1976.; Clarke and Clarke, 1975, *op. cit.*; The President's Committee on Mental Retardation, 1975, *op. cit.*

23. "Identifiable hereditary disorders procuring mental retardation can be divided into two main groups: those caused by defects in the chromosomes and those associated with defects in the genes (contained within the chromosomes)". (Fotheringham, John B. and Mary Morrison, *Prevention of Mental Retardation*. Toronto: National Institute on Mental retardation, 1976). Some forty gene-determined disorders have been identified as causes of mental retardation — some of which have a higher incidence among specific groups within the population, for instance, specifically Tay-Sachs disease which affects a substantive number of Eastern European (Ashkenazi) Jews and their descendants and tyrosinemia which is found mainly in the more isolated regions of Quebec.

    Inheritance factors may however be recessive, dominant or linked to the X-chromosome. Recessive inheritance, responsible for most inborn errors of metabolism, occurs only when both parents contribute the defective gene and therefore there is one chance in four that each offspring of carrier parents will inherit both defective genes and be affected by the disorder. Dominant inheritance requires only one parent to have a defective dominant gene to produce a defective child, in this case the chance effect being fifty-fifty. "The expression of the dominant gene's effects on the individual are highly variable, however, perhaps because the individual may have other genes that have some modulating influence on the act of the abnormal dominant gene". (*ibid.*, p. 31). When the defective gene is carried on one of the sex chromosomes, it is referred to as X-linked inheritance or a sex-linked pattern of inheritance. In these cases, the daughters of unaffected carrier women have a fifty percent chance of inheriting the abnormal gene, but they will not be affected by it themselves because of the presence of a normal gene on the other X-chromosome, however, they will be capable of passing on the condition to their sons.

24. Low birth weight may refer to two separate conditions. There is low birth weight due to "pre-term" birth, in which case the infant is born too early but is an appropriate birth weight for the gestational age. Such an infant would be susceptible to respiratory problems, infections and chemical abnormalities and so on which could result in neurological damage. Low birth weight may also refer to an infant

who is small for his/her gestational age. This latter condition may result from the same conditions that have caused the retardation. That is, neurological damage may result in low birth weight in that case.

25. Although some diseases in themselves are common and not dangerous, infections such as measles and herpes can lead to viral encephalitis and meningitis which may cause permanent and irreversible brain damage.

26. Fotheringham and Morrison, 1976, *op. cit.*; Birch, Herbert G., Stephen A. Richardson, Sir Dugald Baird, Gordon Horobin and Raymond Illsley, *Mental Subnormality in the Community*. Baltimore: The Williams & Willkins Co., 1970; Conley, Ronald W., *The Economics of Mental Retardation*. Baltimore: The Johns Hopkins University Press, 1973; The President's Committee on Mental Retardation, 1975, *op. cit.*; Heber, Rick, *Epidemiology of Mental Retardation*. Springfield: Charles C. Thomas, 1970; Clarke and Clarke, 1975, *op. cit.*; Begab, Michael J., "The Major Dilemma of Mental Retardation: Shall we Prevent it?" (Some Social Implications of Research in Mental Retardation), *American Journal of Mental Deficiency*, 78 (5), 1974.

27. As cited in Birch *et al.*, 1970, *ibid.*, p. 3.

28. Heber, Rick, 1970, *op. cit.*

29. Conley, Ronald W., 1973, *op. cit.*

30. Clarke and Clarke, 1975, *op. cit.*

31. Lewis E. E., "Report on an Investigation into the Incidence of Mental Deficiency in Six Areas" in *Report of the Mental Deficiency Committee, 1925-1927*. London: His Majesty's Stationery Office, 1929.

32. O'Connor, N., and J. Tizard, *The Social Problem of Mental Deficiency*. London: Pergamon Press, 1956.

33. As cited in Birch *et al.*, 1970, *op. cit.*

34. Hopper, Doris, "Retarded Enter Outside World", *Toronto Sun*, June 1978.

35. "Since the frequency of the various grades of intelligence decreases gradually and at no point abruptly on each side of the median, it is evident that there is no definite dividing line between normality and feeble-mindedness . . . The number of mentally defective individuals in the population will depend upon the standard arbitrarily set up as to what constitutes mental deficiency." (Terman (1916) as cited in Conley, 1973, *op. cit.*, p. 8.)

36. National Institute on Mental Retardation, *Orientation Manual on Mental Retardation* (Part I) (Revised Edition). Toronto: National Institute on Mental Retardation, 1977.

37. Davies, Stanley Powell, *The Mentally Retarded in Society*. New York: Columbia University Press, 1959, p. 6.

38. Begab, Michael J., 1974, *op. cit.*

39. Heber, Rick, 1970, *op. cit.*; Conley, Ronald W., 1973, *op. cit.*; National Institute on Mental Retardation, 1977, *op. cit.*; Birch *et al.*, 1970, *op. cit.*

40. Stevenson (1956) as cited in Birch, *et al.*, 1970, *op. cit.*, p. 8.

41. Davies, Stanley Powell, 1959, *op. cit.*

42. As cited in Begab, Michael J., 1974, *op. cit.*, p. 519.

43. Friedman, Paul R., *The Rights of Mentally Retarded Persons*. (An American Civil Liberties Union Handbook) New York: Avon Books, 1976, p. 21. Friedman elaborates by noting that " . . . the dividing line between 'dull-normal' or 'borderline' intelligence and mental retardation is an arbitrary matter, depending upon the demands of a particular society. As a society increases in complexity, fewer of its members are able to adapt to it successfully. Hence the number viewed as 'retarded' is likely to increase".

44. As cited in Clarke and Clarke, 1975, *op. cit.*, p. 4.

45. Shah, Saleem A., "Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior", *Mental Hygiene*, 53 (1) January 1969, p. 32.

46. The origins of the medical model of emotional disturbance are complex, based essentially on moral treatment of the 'insane'. It has been suggested that the label "illness" was first used by Teresa of Avila in the sixteen century to describe emotional disturbed people; it served as a "useful metaphor to protect disturbed nuns (those who exhibited symptoms of hysteria) from the Inquisition". The assumption of "natural" explanations of such behaviour resulted in regarding the behaviour as "not evil". The moral approach relied on compassion, reason, kindness and human interaction as treatment methods. The great debate between the proponents of the medical model and those who believed that emotional and behavioural difficulties belonged in the moral sphere continued until the late nineteenth century when the medical model took precedence. John P. Gray, superintendent of Utica State Hospital and Editor of the American Journal of Insanity, has been attributed as being the most influential medical spokesman for the rejection of the moral approach to insanity and advancing the position that mental patients were really physically ill with an unknown brain disease. Albee, George W., "Emerging Concepts of Mental Illness and Models of Treatment: The Psychological Point of View", *American Journal of Psychiatry*, 125 (7) January, 1969.

47. Shah, 1969, *op. cit.*, p. 22.

48. Shah, 1969, *op. cit.*; Martin, Lealon E., *Mental Health/Mental Illness: Revolution in Progress*. New York: McGraw-Hill Book Company, 1970; Albee, 1969, *op. cit.*; Szasz, Thomas S., *Law, Liberty, and Psychiatry*. New York: The Macmillan Company, 1963, Szasz, Thomas S., *Ideology and Insanity*. New York: Anchor Books, 1970.

49. Martin, 1970, *ibid.*

50. Brooks, Alexander D., *Law, Psychiatry and the Mental Health System*. Boston: Little, Brown and Company, 1974.

51. For a more detailed discussion, see Law Reform Commission of Canada's forthcoming working paper on medical and scientific techniques for treating, altering and controlling personality and behaviour.

52. This perspective has been developed by Szasz, Laing, Brown, Townsend and a variety of others. For a more detailed analysis see Szasz, Thomas, 1963, *op. cit.*, 1970, *op. cit.*, and Szasz, T. (ed.), *The Age of Madness*. New York: Anchor Press/Doubleday, 1973; Laing, R. D., *The Politics of Experience and the Bird of Paradise*. Middlesex, England: Penguin Books Ltd., 1967; Boyers, Robert and Robert Orrill (eds.), *R. D. Laing & Anti-Psychiatry*. New York: Harper & Row, 1971; Brown, Phil (ed.), *Radical Psychology*. New York: Harper Colophon Books, 1973; see also the journal, *The Radical Therapist*.

53. Szasz, Thomas S., 1970, *op. cit.*, p. 15.

54. For a critical analysis of deviance theory, see Taylor, Ian, Paul Walton and Jock Young, *The New Criminology: For a Social Theory of Deviance*. London: Routledge & Kegan Paul, 1973.

55. Wolfensberger, Wolf, et al., *The Principle of Normalization in Human Services*. Toronto: National Institute on Mental Retardation, 1972, p. 13.

56. Szasz, 1970, *op. cit.*

57. Murray, Robin M., "A Reappraisal of American Psychiatry", *The Lancet*, February 3, 1979.

58. The American Psychiatric Association produces a volume entitled *Diagnostic and Statistical Manual of Mental Disorders* which is a list of mental disorders. It includes not only psychoses and neuroses but also learning difficulties, sexual deviations, alcoholism, antisocial behaviour and so on.

59. The term "non-consensual" is used in this paper to encompass any procedure which is carried out without the personal consent of the person involved. It is used therefore to include "involuntary" as well as "non-consensual" in the usual legal meaning.

60. Sources for this section include: Lappé, Marc, "Genetic Knowledge

and the Concept of Health", *The Hastings Center Report*, 3 (4) September 1973; Lappé, Marc, "Can Eugenic Policy be Just?" in *The Prevention of Genetic Disease and Mental Retardation*, A. Milunsky (ed.), Toronto: W. B. Saunders & Co., 1975; Krishef, Curtis H., "State Laws on Marriage and Sterilization of the Mentally Retarded", *Mental Retardation* 10 (3) June 1972; *The Lancet* "Sterilization of Handicapped Minors", II, August 23, 1975; Myers, Henry J., "The Problem of Sterilization: Sociologic, Eugenic and Individual Considerations" in *Abortion in America*. Harold Rosen (ed.). Boston: Beacon Press, 1967; Kittrie, Nicholas N., *The Right to be Different*. Baltimore: The Johns Hopkins University Press, 1971; McWhirter, K. G. and J. Weijer, "The Alberta Sterilization Act: A Genetic Critique", *University of Toronto Law Journal*, 19, 1969; Kratter, Frederick E., "Negative and Positive Eugenic Programs for Mental Defectives", *The Journal of General Psychology*, 63, 1960; Rainone, Francine, "Involuntary Sterilization of the Retarded: Benevolence or Despotism?", July 19, 1974. Unpublished manuscript. The Center for Bioethics Library, Kennedy Institute, Georgetown University, Washington, D.C.; Robitscher, Jonas, 1973, *op. cit.*; Baron, Charles H., "Voluntary Sterilization of the Mentally Retarded" in *Genetics and the Law*. A. Milunsky and G. J. Annas (eds.). New York: Plenum Press, 1976; Murdock, Charles W., "Sterilization of the Retarded: A Problem or a Solution", *California Law Review*, 62, 1974; Fong, Melanie and Larry O. Johnson, "The Eugenics Movement: Some Insight into the Institutionalization of Racism", *Issues in Criminology*, 9 (2) Fall 1974; Ferster, Elyce Zenoff, "Eliminating the Unfit — Is Sterilization the Answer?", *Ohio State Law Journal*, 27, 1966.

61. The development of the procedures of vasectomy for men and salpingectomy or tubal ligation for women.

62. Davies, 1959, *op. cit.*

63. *Buck v. Bell*, 143 Va. 310, 130 S.E. 516 (1925).

64. Ferster, 1966, *op. cit.*, p. 602.

65. Gibson, David, "Involuntary Sterilization of the Mentally Retarded: A Western Canadian Phenomenon", *Canadian Psychiatric Association Journal*, 19(1) February 1974.

66. The Board was composed of four persons. Two of its members were required to be qualified physicians and two were to represent the community at large.

67. R.S.A. 1955, c. 311. The 1928 Act of Alberta was amended a number of times. The initial Act governed any inmate of a mental hospital. If the Board of Governors of such an institution was unanimously of the opinion that ". . . the patient might safely be discharged if the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated . . .", the Board could direct sterilization. Consent of the person was required if the Board considered the person capable or, if not the consent of

his/her spouse, parent, or guardian and if none of these existed, of an appointed provincial Minister. A 1937 Amendment distinguished a psychotic person from a mentally defective person. A psychotic person's consent was still required as specified under the earlier Act, but it became possible to sterilize a mentally defective person without consent. A further Amendment in 1942 extended the Board's powers to include those affected by neurosyphilis, epilepsy with psychosis or mental deterioration and Huntington's Chorea.

68. It should be noted that the Blair Report did not call for the repeal of the law but rather a thorough reworking of the Act and its retention in statutes. The Blair Report of Alberta, "The Eugenics Board" in *Mental Health in Alberta* (A Report on the Alberta Mental Health Study, 1968) Edmonton: Government of Alberta, April 1969.

69. *Ibid.*

70. R.S.B.C. 1960, c. 353, s.5(1).

71. *Ibid.*

72. Williams, Jeremy S. and Carol Etherington, "The Civil Law Relating to the Mentally Retarded". Downsview: National Institute on Mental Retardation, 1970, (unpublished paper).

73. McWhirter and Weijer, 1969, *op. cit.*

74. *Ibid.*, p. 425.

75. Cooke, R. E., "Ethics and Law on Behalf of the Mentally Retarded", *Pediatric Clinics of North America*, 20 (1) February 1973, p. 260.

76. Within the North American context where zero population growth is being rapidly approached on a voluntary basis, it seems unlikely that such a need will arise.

77. For an analysis of the legal questions associated with population control see "Note on Legal Analysis and Population Control: The Problem of Coercion", *Harvard Law Review*, 84, 1971.

78. Champlin, Linda K. and Mark E. Winslow, "Elective Sterilization", *University of Pennsylvania Law Review*, 113, 1965.

79. Guttmacher, T. and V. Welblen, Psychiatry and the Law, 195, 1952 as cited in R. G. Pate and P. B. Plant, "Student Notes — Sterilization of Mental Defectives", *Cumberland-Samford Law Review*, 3, 1972.

80. Royal Commission on Family and Children's Law, *Artificial Insemination* (Ninth Report). Vancouver: Royal Commission on Family and Children's Law, May 1975; Royal Commission on Family and Children's Law, *Part VII Adoption* (Fifth Report). Vancouver: Royal Commission on Family and Children's Law, March 1975.

81. Royal Commission on Family and Children's Law, *Artificial Insemination*, 1975, *op. cit.*, p. 11.

82. Green, Bernard and Rena Paul, "Parenthood and the Mentally Retarded", *University of Toronto Law Journal*, 24, 1974.

83. Murdock, 1974, *op. cit.*

84. For a discussion of marriage see Bass, Medora S., "Marriage for the Mentally Deficient", *Mental Retardation Journal*, August 1964; Mattinson, Janet, *Marriage and Mental Handicap*. London: Duckworth & Co. Ltd., 1970; Craft, Ann and Michael, "Partnership and Marriage for the Subnormal?", *Apex* (Journal of the Institute of Mental Subnormality), 3 (2) September 1975; Floor, L., Baxter, D., Rosen, M., and Zisfein, L., "A Survey of Marriages Among Previously Institutionalized Retardates", *Mental Retardation*, 13 (2), April 1975.

85. Dowben, C., and F. Heartwell, Law Medicine Notes. "Sterilization of the Mentally Retarded", *American Journal of Disease of Children*. (In press).

86. Quoted from the mother of a retarded son in Narot, Rabbi Joseph R., "The Moral and Ethical Implications of Human Sexuality as They Relate to the Retarded" in *Human Sexuality and the Mentally Retarded*. Felix F. de la Cruz and Gerald D. LaVeck (eds.). New York: Brunner/Mazel Publishers, 1973, pp. 203-204.

87. Krishef, 1972, *op. cit.*; Kratter, 1960, *op. cit.*; Weintraub, Philipp, "Sterilization in Sweden: It's Law and Practice", *American Journal of Mental Deficiency*, 56 (2) 1951.

88. Twiss, S. B., "Ethical Issues in Genetic Screening" in *Ethical, Social and Legal Dimensions of Screening for Human Genetic Disease*. Daniel Bergsma (ed.). New York: Stratton Intercontinental Medical Book Corporation, 1974.

89. *Ibid.*

90. Legal arguments against eugenic sterilization laws in the United States have been and are being made on the following six grounds: (1) that it is a cruel and unusual punishment; (2) that it denies equal protection of the laws; (3) that it violates substantive due process; (4) that it violates procedural due process; (5) that it constitutes a bill of attainder; and (6) that it violates a fundamental right to procreate. See Kouri, Robert P., "Certain Legal Aspects of Modern Medicine (Sex Reassignment & Sterilization)". Unpublished thesis, July 1975 (Institute of Comparative Law, McGill University); Becker, Harold K., George T. Felkenes and Paul M. Whisenand, *New Dimensions in Criminal Justice*. Metuchen, N. J.: The Scarecrow Press, Inc., 1968. Dowben and Heartwell, 1979, *op. cit.*; Spriggs, Edward J., Junior, "Involuntary Sterilization: An Unconstitutional Menace to Minorities and the Poor"; *New York University Review of Law and Social Change*, 4, Spring 1974.

91. Ferster, 1966, *op. cit.*, pp. 603-604.

92. See page 26 of this paper.

93. Sorenson, James R., "From Social Movement to Clinical Medicine — The Role of Law and the Medical Profession in Regulating Applied Human Genetics" in *Genetics and the Law*. A. Milunsky and G. J. Annas (eds.). New York: Plenum Press, 1976; Ludmerer, K. M., "American Geneticists and the Eugenics Movement; 1905-1935", *Journal of the History of Biology*, 2, 1969.

94. Ferster, 1966, *op. cit.*, pp. 602-603.

95. *Ibid.*, p. 603.

96. Fraser, F. Clarke and James J. Nora, *Genetics of Man*. Philadelphia: Lea & Febiger, 1975; Milunsky, A., *Know Your Genes*. Boston: Houghton Mifflin Company, 1977.

97. Some geneticists claim that definitive links have been found between schizophrenia and genetic factors but the debate has not been resolved. See, for example, Heston, L. L., "The Genetics of Schizophrenic and Schizoid Disease", *Science*, 167, January 1970; "Genetics of Schizophrenia", *Lancet*, January 3, 1970; Kallmann, Franz J. "The Genetic Theory of Schizophrenia (An Analysis of 691 Schizophrenic Twin Index Families)" in *Readings in Law and Psychiatry*. R. C. Allen, E. Z. Ferster and J. G. Rubin (eds.). Baltimore: The Johns Hopkins Press, 1968; Erlenmeyer-Kimling, L., "Schizophrenia: A Bag of Dilemmas", *Social Biology*, 23 (2) Summer 1976; Kaplan, Arnold R., "Genetics and Schizophrenia", *Eugenics Quarterly*, 14 (4) December, 1967; De Jager, N. S. T., "A Survey of the Genetic and Biochemical Bases of Schizophrenia", *Queen's Medical Review Annual*, 15, 1967-68; Gottesman, Irving I. and James Shields, "Genetic Theorizing and Schizophrenia", *British Journal of Psychiatry*, 122, 1973; Rieder, Ronald O., *et al.*, "The Offspring of Schizophrenics", *Archives of General Psychiatry*, 32, February 1975; Mendlewiez, J., *et al.*, "Evidence for X-Linkage in the Transmission of Manic-Depressive Illness", *American Medical Association Journal*, 222, December, 1972.

98. Tay-Sachs Disease is named after Warren Tay an English physician and Bernard Sachs a New York neurologist. Affected individuals usually develop normally for six months to one year and then begin to undergo deterioration of the central nervous system. Death usually occurs before the fourth birthday. It occurs most frequently among the Ashkenazy or Jews of European origin, with an incidence of 1 in 3,600 births, as compared to 1 in 360,000 births among most non-Jewish populations.

99. Fraser, F. Clarke and James Nora, 1975, *op. cit.*, p. 64.

100. Murdock, 1974, *op. cit.*

101. Kittrie, 1971, *op. cit.*

102. Wallin, "Mental Deficiency", *Journal of Clinical Psychology*, 153, 1956, as cited in Kittrie, N., 1971, *op. cit.*, p. 328. See also, Deutsch, Albert, *The Mentally Ill in America*. New York: Doubleday, Doran and Co. Inc., 1937.

103. Clarke & Clarke, 1975, *op. cit.* See also Smith, G. F. and J. M. Berg, *Down's Anomaly*. Edinburgh: Churchill Livingstone, 1976, pp. 40-41.

104. Kittrie, 1971, *op. cit.*; Thompson, James S. and Margaret W. Thompson, *Genetics in Medicine*. Philadelphia: W. B. Saunders Company, 1966; Golding, Martin P., "Ethical Issues in Biological Engineering", *U.C.L.A. Law Review*, 15 (267) 1968.

105. Penrose, L. S., *The Biology of Mental Defect*. London: Sidgwick and Johnson, 1972 as cited in Clarke and Clarke, 1975, *op. cit.*, p. 11.

106. Meyers, David, *The Human Body and the Law*. Chicago: Aldine and Atherton, 1970, p. 46.

107. Rosen, Harold, *Abortion in America*. Boston: Beacon Press, 1967, p. 89. Similar arguments have been advanced by Rainone, 1974, *op. cit.*; Spriggs, 1974, *op. cit.*

108. See pages 27-28 of this paper for an outline of the Alberta law.

109. Christian, Tim, "The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act", 1974. Unpublished paper. The figures which follow in the text are from that study.

110. *Ibid.*, pp. 89-90.

111. *Ibid.*, p. 90.

112. *Ibid.*, p. 96.

113. *Ibid.*, p. 123.

114. Some historians have traced the movement back to the ancients when people like Aristotle, Plato, and Socrates based the need to control population size on the limited food resources and over-population. Using this reasoning, the ancients practised infanticide, on the basis of caste.

115. Murdock, 1974, *op. cit.*; Mattinson, 1970, *op. cit.*; Mickelson, Phyllis, "The Feebleminded Parent: A Study of 90 Family Cases", *American Journal of Mental Deficiency*, 51 (4) April, 1947.

116. Cochran, Betty, "Conception, Coercion and Control: Symposiums on Reproductive Rights of the Mentally Retarded", *Hospital and Community Psychiatry*, 25 (5) May 1974.

117. Edgerton, Robert B., *The Cloak of Competence*. Berkeley, California: University of California Press, 1967.

118. *Ibid.*

119. See for instance Wolf, Roger O., "Can New Laws Solve the Legal and Psychiatric Problems of Voluntary Sterilization?", *The Journal of Urology*, 93, March 1965. Sim, Myre, J. M. Emens and J. A. Jordan, "Psychiatric Aspects of Female Sterilization", *British Medical Journal*, 3, July 28, 1973.

120. Chez, Ronald A., "Mental Disability as a Basis for Contraception and Sterilization", *Social Biology*, 18 (Supp.), 1971.

121. Wolfensberger, W., et al., 1972, *op. cit.*; de la Cruz, Felix F. and Gerald D. LaVeck, *Human Sexuality and the Mentally Retarded*. New York: Brunner/Mazel Publishers, 1973; Nakra, B. R. S. and R. Gaind, "Psychiatric Aspects of Sterilization", *British Medical Journal*, 4, October 20, 1973; Kurtz, Richard A., William M. Salyers, C. W. Murdock and Jack P. Clark (Participants) *Transcript of "Seminar on Voluntary Sterilization and Optional Abortion"*, Warsaw, Indiana, May 22, 1972.

122. Rosen, 1967, *op. cit.*

123. This study was based on indepth interviews carried out between 1949 and 1958 with fifty mentally retarded individuals who had been sterilized and subsequently released from institutions. It was found that of those persons sixty-eight percent disapproved of the operation, while only twenty percent clearly approved. Between men and women, nine percent of the women and thirty-five percent of the men approved. Married persons were much more likely than unmarried persons to disapprove of sterilization. Most of the women who were neutral or positive in their attitude were close to the end of or past the childbearing age. Sabagh, G. and R. B. Edgerton, "Sterilized Mental Defectives Look at Eugenic Sterilization", *Eugenics Quarterly*, 9, 1962.

124. Roos, Philip, "Psychological Impact of Sterilization on the Individual", *Law and Psychology Review*, 45 (50) Spring, 1975.

125. *Ibid.*, p. 54.

126. The original statement of the principle of normalization (Bank-Mikkelson) was succinctly stated as: " . . . letting the mentally retarded maintain an existence as close to the normal as possible". Since that time the principle has been elaborated upon in the literature [Nirje (1969) Wolfensberger (1972)]. Nirje phrased it as " . . . making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society". (Nirje, Bengt., "The Normalization Principle — Implications and Comments" (Symposium on "Normalization") *Journal of Mental Subnormality*, 16 (2) December 1970).

127. Wolfensberger, 1972, *op. cit.*, p. 28.

128. *Ibid.*, p. 28.

129. See chapter 1 for an elucidation of these two models.

130. Wolfensberger, 1972, *op. cit.*, p. 28.

131. See Friedman, Paul R., 1976, *op. cit.*; also Herr, Stanley S., "Rights into Action: Protecting Human Rights of the Mentally Handicapped", *Catholic University Law Review*, 26 (2) Winter, 1977.

132. U.N. General Assembly Resolution 217A (iii), *Universal Declaration of Human Rights*, December 10, 1948, Article 16(i): "Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage, and at its dissolution."

133. *Proclamation of Teheran*, May 13, 1968, Article 16: "The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and the spacing of their children."

134. *Re D* (a minor) [1976] 1 All E.R. 326, Heilbron, J. at 332 said that sterilization on a child of eleven is a type of operation "which involves the deprivation of a basic human right, namely, the right of a woman to reproduce, and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right."

135. Canadian Bill of Rights, S.C. 1960, c. 44, s. 1(*b*); for a general discussion of equality before the law, see Tarnopolsky, Walter, *The Canadian Bill of Rights*, (Second Edition) Toronto: McClelland and Stewart Ltd., 1975, chapter 8; *R. v. Drybones* [1970] S.C.R. 282; Curr v. R. [1972] S.C.R. 889; *Attorney-General of Canada v. Lavell, Isaac et al. v. Bedard* (1974) 38 D.L.R. (3d) 481.

136. *R. v. Burnshine* (1974) 44 D.L.R. (3d) 584, per Martland, J. at 594.

137. The Criminal Code, R.S.C. 1970, c. C-34 and amendments, s. 148 provides an offence for sexual intercourse with the feebleminded (note, however, that the Law Reform Commission of Canada has recommended its repeal in *Report on Sexual Offences*, 1978). The Canadian Human Rights Act, S.C. 1976-77, c. 33, s. 15(1) provides for special programs for the "physically handicapped".

138. Canadian Bill of Rights, S.C. 1970, c. 44, s. 1(*a*).

139. Canadian Human Rights Act, S.C. 1976-77, c. 33; Charter of Human Rights and Freedoms, S.Q. 1975, c. 6, s. 48; Human Rights Act, S.P.E.I. 1975, c. 72, s. 11(1)(a), (2); Human Rights Act and amendments, S.M., 1977, c. 46, s. 1; Human Rights Act and amendments, N.B.A. 1976, c. 31, s. 1; Human Rights Act, S.N.S. 1974, c. 46, s. 1.

140. Charter of Human Rights and Freedoms, S.Q. 1975, c. 6, s. 48 and s. 10 as amended 1977, c. 6, s. 1 and 1978, c. 9, s. 112, s. 113.

141. Canadian Bill of Rights, S.C. 1960, c. 44.

142. Wald, Patricia, "Basic Personal and Civil Rights" in *The Mentally Retarded Citizen and the Law*. M. Kindred *et al.* (eds.). New York: The Free Press, 1976; Roos, 1975, *op. cit.*

143. See Starkman, B., "The Control of Life: Unexamined Law and the Life Worth Living", *Osgoode Hall Law Journal*, 11 (1) June 1973, in which he maintains that one of the obvious lessons to be learned from the sterilization legislation is that sterilization, like abortion, is no panacea for social and economic problems.

144. Linn, Brian, "Involuntary Sterilization — A Constitutional Awakening to Fundamental Human Rights", *Amicus* (National Centre for Law and the Handicapped) 2 (2) February 1977, p. 47.

145. *Ibid.*, p. 48.

146. For a more complete analysis of the law in relation to surgical operations see Law Reform Commission of Canada's forthcoming working paper on treatment in the criminal law; see also Dworkin, Gerald, "The Law Relating to Organ Transplantation in England", *Modern Law Review*, 33 (4) 1970.

147. Criminal Code, R.S.C. 1970, c. C-34 and amendments, section 245. Also, *Cataford v. Moreau*, [1978] C.S. 933.

148. Criminal Code, R.S.C. 1970, c. C-34 and amendments, section 228. Also, *Cataford v. Moreau*, see endnote 147.

149. Criminal Code, R.S.C. 1970, c. C-34 and amendments, section 202.

150. *Morgentaler v. R.*, [1976] 1 S.C.R. 616 at 650; *R. v. Bourne*, [1939] 1 K.B. 687; *R. v. Newton and Stungo*, [1958] Crim. L. R. 469; see also Dickens, Bernard M. *Abortion and the Law*. London: Macgibbon and Kee, 1966; Williams, Glanville, *The Sanctity of Life and the Criminal Law*. London: Faber and Faber, 1958.

151. Dworkin, 1970, *op. cit.*

152. Sharpe, Gilbert, "Consent and Sterilization", *Canadian Medical Association Journal*, 118 (5) March 4, 1978, p. 591.

153. See, for example, *Marshall v. Curry*, [1933] 3 D.L.R. 260; *Wilson v. Swanson*, [1956] S.C.R. 804; *Murray v. McMurchy*, [1949] 2 D.L.R. 442.

154. Kouri, 1975, *op. cit.*, p. 270.

155. Dworkin, 1970, *op. cit.*

156. Kouri, 1975, *op. cit.*

157. *Cataford v. Moreau*, see endnote 147.

158. A very recent Canadian case is: *In the matter of Eve, a Mentally Incompetent Person*, unreported, June 14, 1979, Supreme Court of Prince Edward Island (Family Division). A recent English case is: *Re D* [1976] 1 All E.R. 326 at 331, but, see *Bravery v. Bravery* [1954] 3 All E.R. 59, [1954] 1 W.L.R. 1169, 98 Sol. Jo. 573, dissent of Denning, L. J.

159. Green, L. C., "Law, Sex and the Population Explosion", *Legal Medical Quarterly*, 1 (2), June 1977; Williams, Glanville, 1958, *op. cit.*; Meyers, D., 1970, *op. cit.*

160. Cohen, Mark E., "*Park v. Chessin*: The Continuing Judicial Development of the Theory of 'Wrongful Life' ", *American Journal of Law and Medicine*, 4 (2) Summer 1978.

161. Per Denning, L. J. in *Bravery v. Bravery*, see endnote 158.

162. *Cataford v. Moreau*, see endnote 147.

163. Criminal Code, S.C. 1968-69, c. 41, s. 13.

164. Kouri, 1975, *op. cit.*; Sharpe, 1978, *op. cit.*; Abella, Rosalie, "The Law of Birth Planning in Canada". A paper prepared for the ACSW, June, 1975; Green and Paul, 1974, *op. cit.*

165. Abella, *ibid.*; Sharpe, 1978, *op. cit.*

166. Williams, Glanville, 1958, *op. cit.*, p. 80; also, Green, L. C. 1977, *op. cit.*, p. 98.

167. The Alternative Draft of a Penal Code for the Federal Republic of Germany recommends that consent to sterilization be made subject to statutory regulation and ought not to be relegated to case law. The suggested statute is as follows:

112. *Consent*

(1) A battery is not illegal if the victim had given his consent.

(2) A *sterilization is not illegal* if carried out by a doctor in accordance with medical standards, the person sterilized had himself consented and

1. the sterilization served to prevent the procreation of offspring possessing serious mental or physical disabilities, or

2. the person sterilized is over 25 years of age and had visited a Counselling Center prior to the operation.

(3) Destruction of the gonads is not illegal if done by a doctor in accordance with medical standards, and the person operated on was at least 25 years of age, had given his consent and had visited a Counselling Center prior to the operation.

(4) A doctor performing an operation described in subparagraphs 2 or 3 on a person over 25 years of age without first availing himself of the prescribed services of the Counselling Center shall be punished by a fine of up to three months.

Alternative Draft of a Penal Code for the Federal Republic of Germany. London: Sweet & Maxwell Limited, 1977, section 112.

168. For a concise statement of the meaning and effect of this term, see National Council of Welfare, *Jobs and Poverty*. Ottawa: National Council of Welfare, June 1977.

169. Royal Commission on Family and Children's Law, *Artificial Insemination*, 1975, *op. cit.*

170. Gouldner, Alvin, *The Coming Crisis of Western Sociology*. New York: Basic Books, 1970, p. 297.

171. Wolfensberger, 1972, *op. cit.*

172. California Department of Health, "Policy Statement Regarding Stigmatizing and Excessive Labelling of Persons with Developmental Special Needs", *Management Briefs*, 3 (2) California Department of Health, March 23, 1977.

173. Glass, Eleanor G., "Restructuring Informed Consent: Legal Theory for the Doctor-Patient Relationship", *Yale Law Journal*, 79, 1971.

174. 1st Report of the Special Committee to Advise the Health Protection Branch on Oral Contraceptives, *Rx Bulletin* Special Issue, 1970; "Oral Contraceptives" (1974) 5 *Rx Bulletin* 56 (summary of second report of the Special Committee); "Oral Contraceptives" (1975) 6 *Rx Bulletin*, Supp. No. 1.

175. Chambers, David, "The Right to the Least Restrictive Alternative" in *the Mentally Retarded Citizen and the Law*. M. Kindred, *et al.* (eds.) New York: The Free Press, 1976, p. 93. See also, Lippman, Leopold, "The Least Restrictive Alternative and Guardianship" in Kindred, *et al.*, 1976, *ibid.*

176. See endnote 174.

177. For a detailed analysis of consent in the medical context, see Somerville, Margaret, *Consent to Medical Care*. Ottawa: The Law Reform Commission of Canada, 1979.

178. It has been reported by persons who work in institutions for the retarded that this is not an uncommon occurrence. No attempt is made

to explain the medical procedure or the consequences. There is no way of determining how frequent this is, since such operations would be listed as voluntary because they would be carried out with the consent of parents or guardians.

179. Price, Monroe E. and Robert A. Burt, "Nonconsensual Medical Procedures and the Right to Privacy" in Kindred, *et al.* (eds.) 1976, *op. cit.*, p. 93.

180. See Somerville, Margaret, 1979, *op. cit.*

181. Letter from D. C. Belyea, Ministry of Health, Ontario to President and Chief Executive office, Niagara General Hospital, May 29, 1978.

182. See Sharpe, Gilbert, 1978, *op. cit.*

183. *Globe and Mail*, December 12, 1978, page 1.

184. *Re D* (a minor) [1976] 1 All E.R., 326. See also, *In the matter of Eve, a mentally Incompetent Person* (endnote 158).

185. Price and Burt, 1976, *op. cit.*, p. 109.

186. See Section V — Proposals Regarding Sterilization Procedures for the Mentally Handicapped, page 85 of this paper.

187. Dowben, 1979, *op. cit.*; Ferster, 1966, *op. cit.* outlined the criteria for determining applicability of involuntary sterilization laws and the procedural requirements of the laws.

188. Montana Rev. Code Ann. #69-6401 (1947) as amended (Supp. 1974) as cited in Neuwirth, G. S., *et al.*, "Capacity, Competence, Consent: Voluntary Sterilization of the Mentally Retarded", *Columbia Human Rights Law Review*, 6 (2) Fall-Winter 1974-75, p. 462.

189. *Ibid.*, p. 462.

190. *Ibid.*, pp. 462-463.

191. Court Order (January 8, 1974) Setting Standards to Govern Sterilization of Institutional Residents. *Wyatt v. Aderholt*, 368 F. Supp. 1383 (M.D. Ala. 1974).

1. (a) "Sterilization", as used in these standards, means any medical or surgical operation or procedure which results in a patient's permanent inability to reproduce.

   (b) A determination that a proposed sterilization is in the best interest of a resident, as referred to in these standards, must include a determination that no temporary measure for birth control or contraception will adequately meet the needs of such resident, and shall not be made on the basis of institutional convenience or purely administrative considerations.

2. No resident who has not attained the chronological age of 21 years shall be sterilized except in cases of medical necessity as determined in accordance with the procedures set forth below. No other resident shall be sterilized except in accordance with procedures set forth below.

3. No resident shall be sterilized unless such resident has consented in writing to such sterilization. Except as set forth below, such consent must be informed, in that it is (a) based upon an understanding of the nature and consequences of sterilization, (b) given by a person competent to make such a decision, and (c) wholly voluntary and free from any coercion, express or implied. It shall be the responsibility of the Director of the Partlow State School (with the assistance of employees or officials designated by him) to provide the resident with complete information concerning the nature and consequences of sterilization, to assist the resident in comprehending such information, and to identify any barriers to such comprehension.

4. The Director shall prepare a report evaluating the resident's understanding of the proposed sterilization and describing the steps taken to inform the resident of the nature and consequences of sterilization. If the resident has been determined by a court of competent jurisdiction to be legally incompetent, or if the Director cannot certify without reservation that the resident understands the nature and consequences of sterilization, the sterilization shall not be performed unless (a) the Director sets forth reasonable grounds for believing that such sterilization is in the best interest of the resident; (b) the Review Committee described below approves such sterilization; and (c) it is determined by a court of competent jurisdiction that such sterilization is in the best interest of the resident.

5. No sterilization shall be performed without the prior approval of a Review Committee formed in accordance with this paragraph. The Review Committee shall consist of five members, and shall be selected by the Partlow Human Rights Committee and approved by the Court. The members shall be so selected that the Committee will be competent to deal with the medical, legal, social and ethical issues involved in sterilization; to this end, at least one member shall be a licensed physician, at least one shall be a licensed attorney, at least two shall be women, at least two shall be minority group members and at least one shall be a resident of the Partlow State School (the foregoing categories are not mutually exclusive). No member shall be an officer, employee, or agent of the Partlow State School, nor may any member be otherwise involved in the proposed sterilization.

Any fees or costs incurred by reason of services performed by the Review Committee, including reasonable fees for the physician and the attorney, shall be paid by the Alabama Department of Mental Health upon a certification of reasonableness by the Partlow Human Rights Committee.

6. Prior to approving the proposed sterilization of any resident, the Review Committee shall:

   (a) Review appropriate medical, social and psychological information concerning the resident, including the report of the Director prepared pursuant to paragraph 4;

   (b) Interview the resident to be sterilized;

   (c) Interview concerned individuals, relatives, and others who in its judgment will contribute pertinent information;

   (d) Determine whether the resident has given his or her informed consent to the sterilization, or, if the resident is legally incompetent or the Director cannot certify without reservation that the resident understands the nature and consequences of sterilization, whether the resident has formed, without coercion, a genuine desire to be sterilized. In making such determination, the Review Committee shall take into consideration, *inter alia*, the report prepared by the Director pursuant to paragraph 4 and the interview required by paragraph 6(b);

   (e) Determine whether the proposed sterilization is in the best interest of the resident.

If the Review Committee does not reach an affirmative determination as to the matters set forth in paragraphs 6(d) and (e), it shall not approve the proposed sterilization. Any doubts as to such matters shall be resolved against proceeding with sterilization.

7. Residents shall be represented throughout all the procedures described above by legal counsel appointed by the Review Committee from a list of such counsel drawn up by the Partlow Human Rights Committee and approved by the Court. Such counsel shall, *inter alia*, ensure that all considerations militating against the proposed sterilization have been adequately explored and resolved. No such counsel shall be an officer, employee, or agent of the Partlow State School, nor may such counsel be otherwise involved in the proposed sterilization.

8. The Review Committee shall maintain written records of its determinations and the reasons therefore, with supporting documentation. Such records shall be available for examination by the Partlow Human Rights Committee, the Court, and counsel of record in this cause. The Review Committee shall report in writing at least monthly to the Human Rights Committee, the Court, and counsel of record in this cause as to the number and nature of sterilizations approved and disapproved, the procedures employed in approving or disapproving such sterilizations, the reason for determining that such sterilizations were in the best interest of the residents involved, the number and nature of proposed sterilizations referred to courts of competent jurisdiction, and all other relevant information. The identity of residents sterilized or to be sterilized shall not be disclosed in such reports.

9. There shall be no coercion in any form with regard to sterilization of any resident. Consent to sterilization shall not be made a condition for receiving any form of public assistance, nor may it be a prerequisite for any other health or social service, or for admission to or release from the Partlow State School. Any individual having knowledge of coercion of any resident with regard to sterilization shall immediately bring such matter to the attention of the Partlow Human Rights Committee, the Court, or counsel of record in this cause.

It is further ordered that the defendants, their agents, employees and those acting in concert with them be and each is hereby enjoined from failing to implement the standards hereinabove set out for the sterilization of mentally retarded residents of the Alabama retardation facilities.

Done, this the 8th day of January, 1974.

From: Price and Burt, "Nonconsensual Medical Procedures and the Right to Privacy" in Kindred, M., *et al.*, 1976, *op. cit.*, p. 110.

192. The final regulations were published at: 43 Federal Register 52146. November 8, 1978. *Source:* Health Law Project Library Bulletin 4(1): 18 (January 1978).

193. Green and Paul, 1974, *op. cit.*

194. The Model Voluntary Sterilization Act: Drafted by the Association for Voluntary Sterilization. (From Neuwirth, G. A., *et al.*, 1974-75, *op. cit.*)

A. Model Voluntary Sterilization Act

Sec. 1. Purpose of the Act

This legislature recognizes that any legally competent person as provided herein may consent to voluntary sterilization. Further, the legislature intends to provide a method through proper hearing whereby mentally retarded persons, who would be diagnosed as capable of consent to sterilization but whose legal competence to consent has been questioned by a licensed physician, may voluntarily consent to sterilization.

Sec. 2. Voluntary Sterilization for Competent Persons

a. A licensed physician may perform a sterilization upon any person over twenty-one (21) years of age, or over eighteen (18) years of age and married, [or otherwise emancipated under state law] who is mentally competent to consent and who does in fact consent to be sterilized.

b. Consent shall be freely and intelligently given in writing. Free and intelligent consent shall require that a [physician] [appropriate expert] inform such person as to

1. Method of sterilization;
2. Nature and consequences of such sterilization;
3. Likelihood of success;
4. Alternative methods of sterilization;
5. Alternative methods of birth control;

and be satisfied that such consent has been given after full and fair deliberation of these matters.

[If an individual is a member of a particular ethnic, religious or philosophical group, he or she shall be afforded the opportunity to confer with a representative of the group concerned, if the individual so desires.]

Sec. 3. Voluntary Sterilization for Retarded Persons

a. The persons to whom this section is applicable are those mentally retarded persons of any age who have the capacity to understand and appreciate the nature of the medical treatment they are to undergo and the consequences thereof and to manifest assent or dissent thereto.

b. Any person to whom this section is applicable and whose legal competence to consent has been questioned by a licensed physician or might be so questioned, may consent to voluntary sterilization after application to and approval by the Review Committee as hereinafter provided and, if an appeal is taken, by the [ ] Court.

Sec. 4. Review Committees Established

To carry out the purposes and provisions of this act, there is hereby created and established for each [federal judicial district] in the state of [ ] a Review Committee which shall consist of the following:

a. One (1) physician licensed to practice psychiatry in the state to be appointed for a term of three (3) years by the governor after considering the recommendation of the state medical association;

b. One (1) lawyer licensed to practice law in the state to be appointed for a term of three (3) years by the governor after considering the recommendation of the state bar association;

c. One (1) lay member to be appointed for a term of three (3) years by the governor after recommendations by qualified organizations in the field of mental retardation;

d. A consulting physician, either a licensed specialist in urology or in gynecology and obstetrics as appropriate, to be selected by the members of the committee appointed as provided in a, b, and c;

e. A representative of the particular ethnic, religious, or philosophical group of the applicant to be selected by the members of the committee appointed in a, b, and c;

[f. An ex officio member who shall act as the committee's secretary and the keeper of its books and records,]

provided that no committee member, except as appointed in f, shall be otherwise employed by the state. Nor shall a member engaged in the custodial or professional care of an individual applicant, or previously engaged in the [professional] care of such applicant, or personally related to him or her, participate in the committee's consideration of that individual's application.

Sec. 5 Application for Sterilization

It shall be the duty of the Review Committee to receive applications for voluntary sterilization by or on behalf of persons claiming eligibility under Sec. 3 of this act. The applicant himself, or a parent or legal guardian or custodian of the applicant, may file papers in any form calculated to apprise the committee of the desire of the applicant to be sterilized.

Upon receipt of such application, the Review Committee shall appoint a patient advocate for the individual requesting sterilization, unless the individual has already obtained counsel, and shall schedule a hearing not less than [20] days nor more than [45] days after such appointment, or, if no appointment, after receipt of the application.

Further, the committee shall notify any parent(s), legal guardian, and/or custodian of the applicant of the nature, location, date, and time of such hearing [by registered mail].

Sec. 6. Patient Advocate

If an applicant cannot afford or otherwise obtain counsel, he shall be furnished with a patient advocate. Counsel, or such patient advocate as designated herein, shall represent the expressed wishes of the applicant regardless of who may initiate the proceedings or pay the attorney's fee. The committee shall have discretion to appoint a patient advocate for any applicant, regardless or whether a parent or legal guardian or custodian has provided counsel for applicant.

The patient advocate shall be an attorney licensed by the state and qualified to protect the rights and legal interests of the applicant.

Sec. 7. Hearing — Showing Required — Designation of Surgeon — Written Consent

The Review Committee shall conduct a hearing at which the applicant must be present in person for examination by the board and evidence must be presented to establish:

a. Whether the applicant is one of the group covered by Sec. 3.a of this act:

b. Whether the applicant, whether or not a minor, has been counselled as to the nature and consequences of sterilization as defined in Sec. 2.b of this act and whether the applicant understands and appreciates such information and voluntarily assents thereto:

c. If the applicant is under twenty-one (21) years of age, whether his or her parent(s), if living and competent, or, if not, his or her legal guardian understands and consents to the sterilization;

d. If the applicant is over twenty-one (21) years of age, whether any parent(s) or legal guardian who is in custody of the applicant understands and consents to the sterilization;

e. Whether any undue coercion or promise of release from an institution has induced the applicant's consent;

f. Whether sterilization is otherwise ill-advised or whether an applicant is unable or unlikely to procreate;

g. Whether such treatment can be carried out without unreasonable risk to the life and health of the applicant;

h. The method and manner in which sterilization is to be accomplished.

Further, at such hearing the applicant shall designate the person to perform such sterilization who may be any physician and surgeon licensed to practice medicine in the state.

At such hearing, the applicant shall sign a written consent to sterilization in the form to be provided by the committee.

Sec. 8. Notification of Findings — Appeal of Right to [ ] Court — Certificate

Within [three (3)] weeks after the hearing, the Review Committee shall make its findings in writing. It shall be the duty of the committee to supply a copy of the findings to the applicant, counsel or patient advocate, and any parent(s) or legal guardian or the applicant. Within [two (2)] weeks of receipt of the findings, any party so notified shall have an appeal of right to the [ ] Court for review of any of the findings made. Notice of the appeal shall be served on the committee and all parties notified of the findings. Such appeal will automatically stay the effect of the findings until court review has been completed.

If no appeal is taken within the designated period, the committee shall make a certificate reciting its findings and signed by all members of the committee. The certificate shall conspicuously state the commit-

tee's "Approval of Sterilization" or "Disapproval of Sterilization". The original of such certificate shall be sent to the physician designated by the applicant to perform the sterilization; copies thereof shall be sent to the applicant, counsel or patient advocate, and any parent(s), legal guardian or custodian, and one copy to remain the permanent files of the committee.

Sec. 9. Findings Prerequisite to Approval of Sterilization — Operation Arranged

If the Review Committee finds and certifies

a. That the applicant is one of the group covered by Sec. 3.a of this act;

b. That the applicant, whether or not a minor, has been counselled as to the nature and consequences of sterilization as defined in Sec. 2.b of this act and that he or she understands and appreciates this information and voluntarily assents thereto;

c. That any parent(s) or legal guardian of a minor applicant, or any parent(s) or legal guardian who is in custody of an applicant over the age of twenty-one (21) has understood and consented to the sterilization in writing;

d. That no undue coercion or promise of release from an institution has induced the applicant's consent;

e. That sterilization is not otherwise ill-advised.

f. That the method and manner in which such sterilization is to be accomplished is medically approved according to the standards of such procedures in the state;

g. That such medical treatment can be carried out without unreasonable risk to the life or health of the applicant;

h. That the person designated to perform such sterilization is one qualified under this act;

the physician designated to perform the sterilization, upon receipt of the certificate issued by the Review Committee, may proceed with treatment in accordance with the certificate. Arrangements for such medical treatment shall be made between the physician designated in the certificate and the applicant or his or her parent, guardian or custodian. Provided nothing in this act shall be deemed to prohibit payment in whole or in part for the treatment by any federal or state program, agency or department.

Sec. 10. No Civil Liability Arises from Sterilization — Exception

Neither the members of the Review Committee nor any physician and surgeon or assistant concerned nor any other person participating

in the execution of the provisions of this act in conformity with the board's certificate shall be thereafter liable either civilly or criminally to anyone having performed or authorizing the performance of such sterilization; provided, that such physician or surgeon or assistant concerned will nevertheless be liable for any damage caused by the negligent performance of such sterilization in accordance with the general law of the state covering such negligence.

195. Wolfensberger, Wolf, *A Balanced Multi-Component Advocacy/Protection Scheme*. Toronto: Canadian Association for the Mentally Retarded, 1977; Wolfensberger, Wolf, 1972, *op. cit.*; Wolfensberger, Wolf and Helen Zauha, (eds.). *Citizen Advocacy and Protective Services for the Impaired and Handicapped*. Toronto: National Institute on Mental Retardation, 1973.

196. New Zealand, "Contraception, Sterilisation and Abortion Act", 1977 (came into force 1 April 1978)*.

Sterilisation

7. Application for order authorising sterilisation of mentally subnormal person —

(1) In this section and *sections 8 to 11* of this Act, a person is mentally subnormal if he is suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.

(2) An application to the Supreme Court for an order authorising the sterilisation of any person (hereafter in this section and *sections 8 to 11* of this Act referred to as the patient) who is believed by the applicant to be mentally subnormal may be made —

(a) By the parent or guardian of the patient, or by any person who is acting in the place of a parent of the patient:

(b) The superintendent, manager, or licensee of any hospital, home, or other establishment in which the patient is resident:

(c) A registered medical practitioner:

(d) A social worker concerned professionally with the patient.

(3) Every application shall be in the prescribed form.

(4) Where the application is made by any person other than a person to whom *subsection (2)(a)* of this section applies, the

* This Act was based on a report of the New Zealand Royal Commission of Inquiry on Contraception, Sterilisation and Abortion (March, 1977).

applicant shall serve a copy of the application on the parent or guardian of the patient, or on any person who is acting in the place of a parent of the patient.

(5) Where the application is made by any person who is not a registered medical practitioner, it shall be supported by a certificate by a registered medical practitioner to the effect that, in his opinion, the patient is mentally subnormal.

(6) In every case, the application shall be supported by a statement by a person qualified in that behalf giving his professional assessment of the patient's social adjustment and intellectual capacity.

(7) On any such application the Court may give such directions as to service as it thinks fit.

(8) Except where the Court otherwise orders, the costs of and incidental to every application under this section shall be met out of money from time to time appropriated by Parliament for the purpose.

8. Examination by Court and two medical practitioners —

(1) On the lodging of the application for an order under *section 7* of this Act, the Court shall examine the patient at his residence or elsewhere, and for the purpose of further inquiry shall call to its assistance 2 medical practitioners who shall either together or separately examine the person.

(2) Unless in the opinion of the Court there is sufficient reason to the contrary, one of the medical practitioners called to its assistance shall be the usual medical attendant of the patient.

(3) The Court may also summon as witnesses such persons as it thinks fit to give evidence touching the mental condition of the patient.

(4) If, after such examination, the medical practitioners are of the opinion that the patient is mentally subnormal or one of them is of that opinion, each of them, or the one that is of that opinion, shall sign and deliver to the Court a certificate to that effect in the prescribed form, setting forth in the certificate the facts observed by him upon which his opinion is based.

(5) Every such medical certificate shall bear the date of the day on which the certifying medical practitioner last examined the person alleged to be mentally subnormal before the signing of the certificate.

(6) If, after such examination, either of the medical practitioners is of the opinion that the said person is not mentally subnormal, or that he may be mentally subnormal, he shall sign

and deliver to the Court a statement in writing of his opinion, and, except as provided in *subsection (7)* of this section, the Court shall not accept in substitution for that opinion the opinion of any other medical practitioner.

(7) Notwithstanding anything in this section, in any such inquiry the Court may, if it thinks fit, accept any medical certificate accompanying the application as if the medical practitioner who signed it had been duly called to its assistance under this section.

9. Court to appoint counsel to represent patient — On any application under *section 7* of this Act, the Court shall appoint counsel to represent the interests of the patient.

10. Determination of application — If, on receiving medical certificates from 2 medical practitioners in accordance with *section 8* of this Act, to the effect that the patient is mentally subnormal, and after hearing such evidence as may be adduced on behalf of the patient and such other evidence as the Court thinks fit, the Court is satisfied that the person is mentally subnormal and that, for his own good, he should be sterilised, the Court may make an order in the prescribed form granting the application.

11. Effect of order — Every such order shall be sufficient authority to the person therein named to arrange for the performance on the patient of any medical or surgical procedure intended to render the patient sterile by any person professionally qualified to carry out that procedure, and to give any necessary consent to the carrying out of that procedure.

12. Reports on sterilisations —

(1) Every registered medical practitioner who performs an operation of sterilisation shall, within 1 month thereafter, forward to the Director-General of Health a report of the operation giving the following particulars:

(a) The reasons for the operation:

(b) The age, sex, marital status, race, and number of children of the patient:

(c) Whether the patient stayed in hospital for 1 or more nights:

(d) Whether the operation was performed post-partum:

(e) Where the operation was carried out pursuant to an order of the Court made under *section 10* of this Act, that fact.

(2) No such report shall give the name or address of the patient.

(3) Every registered medical practitioner who fails to comply with *subsection (1)* of this section, or contravenes *subsection (2)* of this section, commits an offence and is liable on summary conviction to a fine not exceeding $100.

13. Conditions relating to sterility not to be attached to loans —

(1) It shall be unlawful for any person (in this section referred to as the lender) —

(a) To require any other person (in this section referred to as the borrower), or the borrower's spouse, as a condition of granting any loan, to undertake to become sterile; or

(b) To refuse to grant any loan to the borrower merely because the borrower or the borrower's spouse is not sterile.

(2) Every person who suffers any loss by reason of any act or omission rendered unlawful by *subsection (1)* of this section shall be entitled to recover damages from the person responsible for the act or omission.

197. American Association on Mental Deficiency, "Sterilization of Persons Who Are Mentally Retarded" (Proposed Official Policy Statement of the A.A.M.D.), *Mental Retardation*, 12 (2) April 1974.

198. The Canadian Association for the Mentally Retarded has made no formal policy statements, and of the provincial associations only British Columbia and Ontario have developed policies.

199. Ontario Association for the Mentally Retarded, "Brief to The Interministerial Task Force on Sterilization, Part I: Summary of Recommendations" Toronto: Ontario Association for the Mentally Retarded, April 7, 1979.

200. The other recommendations proposed regarding consent and related matters are:

(a) *General*

1. The complete law dealing with consent to treatment, including all non-therapeutic treatments, should be contained in one statute.

2. There should be one law covering consent to treatment for all citizens, regardless of treatment setting or treating authority. The only exception should be where extraordinary treatments are proposed for persons involuntarily incarcerated in correctional or psychiatric facilities.

(b) *Sterilization*

(see above pp. 96-99)

(c) *Consent*

16. Under no circumstances should a person who is competent to give a valid consent to treatment be subjected to involuntary treatment. It is therefore recommended that subsections 31a (4), (5) and (6) and the words "except under the authority of an order of a regional review board made on the application of the officer in charge" from subsection 31a (2) of the *Mental Health Act 1978* be repealed.

17. In line with recommendation 1 (supra) the elements of a legally valid consent to treatment should be clearly specified in the legislation.

    To be valid a consent must be "voluntary" *i.e.* freely given by a person who is not overtly or covertly coerced or under duress and is free from express or implied inducements other than the benefits to be derived from the treatment.

18. To be valid a consent must be "informed" *i.e.* the patient must be informed of:

    (i) the nature of his condition or disorder;

    (ii) the potential benefits to be derived from the treatment;

    (iii) the discomforts and risks (including possible side effects) which may accompany or result from the treatment;

    (iv) the alternatives, particularly less drastic or restrictive alternatives, to the recommended treatment; and

    (v) his right to withhold or withdraw consent at any time.

19. When a person is being informed about the proposed treatment, the material being presented should be in language understandable to the patient and where necessary an interpreter should be provided.

(d) *Legal Capacity*

20. Parents or guardians should continue to provide a substituted consent to the therapeutic treatment of minors under the age of sixteen, unless failure to consent constitutes neglect, in which case the Children's Aid Society should become involved.

21. There should continue to exist a presumption that every person has the mental capacity to give a valid consent to treatment until such time as an independent tribunal finds to the contrary.

22. The only exception to the foregoing principle would be in cases of "medical emergency". The emergency power contained in regulations under the *Public Hospital Act* should be transferred to the new statute dealing with consent to treatment. A definition of "medical emergency" should be included which provides that the consequences of waiting to appear before an independent tribunal would be "imminent and serious physical harm to the person".

23. After an operation has been performed in a medical emergency, the person should be provided with all the information he would have received so that his consent might have been "informed". In addition he should receive a written statement of the circumstances which comprised the medical emergency.

24. The test for mental capacity should be whether or not the patient has the ability to understand the risks, benefits, and alternatives to treatment, including no treatment.

25. A person's capacity to consent will vary depending upon his ability to be informed and to withstand more subtle forms of coercion. It should be specified in the legislation that where a medical practitioner decides a person has the mental capacity to give a consent but has reason to believe his decision may be challenged at a later date, an advocate who is completely independent of the health or social service delivery system should be appointed. The medical practitioner or other interested person could make an application for the appointment of an advocate. The advocate together with the patient would decide whether the person's mental capacity should be reviewed by a Court. Additionally the advocate would strengthen the patient's ability to make the decision.

26. Where a professional recommending treatment decides a person lacks the requisite mental capacity, and a "medical emergency" does not exist, the professional or any other interested party may apply to the Court for a ruling on this issue.

27. Except where the patient has retained legal counsel, an independent advocate should be provided. Where the patient refuses the advocate's services, or where in the advocate's opinion the patient is not competent to instruct the advocate, the advocate shall serve as *amicus curiae* with the same rights as the parties to the proceedings.

28. The advocate should be under a statutory obligation to serve the "best interests" of the patient as that term is defined in a long line of American cases.

29. The Court should be based upon the adversary model with a procedure which at a minimum includes the safeguards pro-

vided under the *Statutory Powers Procedures Act*. All relevant material should be available to the patient. Therefore, it is recommended that sub-sections 26a (6) and (7) of the Mental Health Act be amended to assure that the patient has unrestricted access to the clinical record.

30. Due to the potential for coercion of a person incarcerated in a correctional or psychiatric facility, no such person should be subjected to a non-therapeutic treatment. "Psychosurgery" in section 31a (1) of the Mental Health Act is a useful example of this principle. Amongst such non-therapeutic treatments we would include non-therapeutic sterilizations and "experimental operations" as defined in *Halushka v. University of Saskatchewan* (1965) 53 D.L.R. (2d) 436 (Sask. C.A.). Whether or not an abortion is therapeutic should continue to be governed by section 251 of the *Criminal Code*.

201. Personal correspondence with Dr. Norman Brown, Secretary-Treasurer of the Canadian Medical Protective Association, October 26, 1978.

202. Zarfas, Donald E., "Sterilization of the Mentally Retarded" (Speech presented at the Ontario Psychiatric Association Meeting, London, Ontario, October 5, 1978). In this presentation, Dr. Zarfas presented the following figures on sterilization procedures carried out on persons under the age of 18 years in Ontario.

January to December 1976

	Procedure	*Number of Claims*
5626 —	Vasectomy	50
5741 —	Female ligation	135
5757 —	Hysterectomy - total abdominal or vaginal	68
5758 —	Hysterectomy - with Cystocele and Rectocele	23
5759 —	Hysterectomy - with Cystocele or Rectocele	18
5033 —	Sterilization - Post partum	14

Zarfas states that he has been advised by "competent obstetricians that there are few, if any, indications for such procedures other than mental retardation".

203. No other provincial medical association has developed a policy statement specifically directed to sterilization of persons who are mentally handicapped.

204. According to the proposal, these guidelines were developed to satisfy the following imperatives:

(1) Adequate patient care.

(2) Appropriate diagnostic assessment of mentally retarded persons prior to reaching a conclusion for or against the sterilizing operation.

(3) Establishment of a sufficiently broad base of responsibility for the procedure to protect from litigation:

(a) the surgeon

(b) the hospital in which the operation is performed.

They have these objectives:

(1) To make available the benefits of sterilization procedures to persons who might benefit.

(2) To minimize the embarrassments, anguish and expense to the parents presenting mentally retarded children for sterilization procedures.

(3) To adequately protect mentally retarded persons from inappropriate surgical procedures for sterilization.

(4) To provide an optimum measure of legal protection to the surgeon performing the operation, keeping in mind the medical-legal ambiguities currently existing in all medical and surgical procedures especially surrounding the concept of informed consent.

(5) To minimize the cost to the community while maximizing the benefit to the patient.

(6) To make it possible for sterilizing procedures to be done in community hospitals that do not have readily at hand the full complement of consulting personnel.

(7) To retain responsibility for this medical-surgical procedure in the hands of those who are ultimately accountable.

205. These are adopted from the recommendations of Zarfas, Donald E., 1978, *op. cit.*

206. See Law Reform Commission of Canada's forthcoming Working Paper on treatment in the criminal law.

207. Law Reform Commission of Canada, *Report on Family Law*. Ottawa: Law Reform Commission of Canada, 1976. See also, Law Reform Commission of Canada, *The Family Court* (Working Paper 1). Ottawa: Law Reform Commission of Canada, January 1974.

208. Roth, Loren H., Alan Meisel and Charles W. Lidz, "Tests of Competency to Consent to Treatment", *American Journal of Psychiatry*, 134 (3) March, 1977.

209. See Law Reform Commission of Canada's forthcoming Working Paper on treatment in the criminal law.

210. This confers with the age specified by the Uniform Medical Consent of Minors Act which follows.

211. Alberta Institute of Law Research and Reform, *Consent of Minors to Health Care*, Report No. 19, December 1975; Picard, Ellen, "Recent Developments in Medical Law", *Legal Medical Quarterly*, 1 (3) 1977.

212. Law Reform Commission of Saskatchewan, *Tentative Proposals for a Consent of Minors to Health Care Act*. Saskatoon: Law Reform Commission of Saskatchewan, November 1978.

213. Uniform Law Conference of Canada, "Medical Consent of Minors Act", Draft 22, September 1975; see, for New Brunswick, "Medical Consent of Minors Act", N.B.A., 1976, c. M-6.1.